BELLA VISION
Derrick I Choe, OD & Associates

NEW PATIENT INFORMATION

Patient Information

Last Name: _____ First Name: _____ M.I. _____

Date of Birth: _____ Sex: ☐ M ☐ F Status: ☐ Single ☐ Married ☐ Other

Address: _____ ☐ Employed ☐ Full Time Student

City: _____ State: _____ Zip Code: _____ Phone: (_____) _____

Email Address: _____ Would you like a reminder email in one year for your next annual comprehensive eye exam? ☐ Yes ☐ No

Insurance Information

Vision Insurance Company _____ Are you the primary policy holder? ☐ Yes ☐ No

ID: _____ Policy Holder's Employer _____

Group: _____ Relationship to Patient? ☐ Self ☐ Spouse ☐ Parent

Medical Insurance Company _____ *(If patient is also the policy holder, the following may be left blank)*

ID: _____ Name of Policy Holder: _____

Group: _____ Policy Holder's Date of Birth: _____

Reason for Today's Visit *(please check all that apply)*

☐ Annual routine comprehensive exam

☐ New/Update glasses prescription

☐ New/Update contact lenses prescription
(Additional Evaluation & Fitting Required)

☐ Medical Office Visit (infection, red eye, etc)

☐ Interested in LASIK

☐ Other _____

Retinal Screening or Dilation

Please screen my retina, including the optic nerve for ocular diseases by:

☐ **Digital Retinal Imaging** - $40 charge, most insurances do not cover.

During your comprehensive exam we will be performing Digital Retinal Imaging (DRI). This technology involves capturing a high-resolution digital image of the interior portion of your eye. This provides us with a digital retinal fingerprint and serves as a baseline for eye-health comparison for future visits.

* OUR DOCTORS HIGHLY RECOMMEND THIS SCREENING

☐ **Conventional Dilation -** Covered by insurance.

If you opt to not do the Digital Retinal Imaging, we will have to Dilate your eyes. Dilation drops can cause blurred near vision, sensitivity to light, and can last 2-4 hours depending upon each person.

Retinal Screening is recommended every 1-2 years. Please initial if you would like to defer retinal screening to a later date or next year. _____
Please note that under certain circumstances, the doctor may require further evaluation where dilation is required.

Please Initial the Following

_____ As a service to our patients, we would be happy to verify and bill your insurance on your behalf. However, with all insurance companies, we need to advise you that *all benefits are just a quote of benefit, not a guarantee of payment*. I understand that for any reason my insurance does not pay the estimated benefit, I will be responsible for the amount.

_____ I acknowledge that I have received the Notice of Privacy Practices from Bella Vision. I authorize payment of medical benefits to Bella Vision for the services provided at the facility.

Patient Signature: _____ Date: _____