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:

☐ **Retinal Photos**

Pros: Takes less than one minute
No side effects
Hard copy to chart progress
Cons: Not covered by insurance, $30.00 charge

-OR-

☐ **Conventional dilation**

Pros: Covered by insurance, no charge
Cons: Blurred near vision for 4 to 6 hours
Sensitivity to light and glare
Takes an additional 20 to 30 minutes

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: _____