PATIENT INFORMATION and MEDICAL HISTORY FORM
Dr. Edward Bancroft, Optometrist

Last Name_____First_____MI____Nickname_____
Birthdate_____Last 4 digits of SS#_____ Male ◯ Female ◯
Mailing Address_____City_____State___Zip_____
Primary Phone_____ Cell ◯ HM ◯ WK ◯ Phone 2_____ Cell ◯ HM ◯ WK ◯
Email_____ Married ◯ Single ◯
Employed Full time ◯ Part Time ◯ None ◯ Occupation_____
Spouse or Parent's Name(if minor)_____Phone_____
Who may we Contact in case of an emergency_____Phone_____
Who may we thank for referring you?_____

Primary Vision Insurance Information
Name of Insurance Company_____Member ID #_____
Primary insured's Employer_____
Name of primary insured_____Relationship to Patient Self
Primary insured's Date of Birth_____Primary insured's Last 4 SS_____

Secondary Vision Insurance Information
Name of Insurance Company_____Member ID #_____
Secondary insured's Employer_____
Name of secondary insured_____Relationship to Patient Self
Secondary insured's Date of Birth_____Secondary insured's Last 4 SS_____

Primary Medical Insurance Information
Name of Insurance Company_____Member ID #_____
Primary insured's Employer_____
Name of primary insured_____Relationship to Patient Self
Primary insured's Date of Birth_____Primary insured's Last 4 SS_____

Secondary Medical Insurance Information
Name of Insurance Company_____Member ID #_____
Secondary insured's Employer_____
Name of Secondary insured_____Relationship to Patient Self
Secondary insured's Date of Birth_____Primary insured's Last 4 SS_____

☐ I acknowledge that I have read and signed the Statement of Financial Responsibility. (PG 3)
☐ I acknowledge that I have received a copy of the HIPPA privacy policy. (PG4)

Signatures can be done in the office .

Signature or Parent Signature (if minor)_____Date_____

Name:

Eye History

Date of Last Eye Exam_____

Currently wear Glasses? ○ Yes ○ No

Currently wear Contacts? ○ Yes ○ No

_____

Have you or a family member experienced, or been treated for, any of the following? Check all that apply.

- ☐ Cataract
- ☐ Crossed Eyes
- ☐ Glaucoma
- ☐ Lasik or PRK
- ☐ Lazy Eye
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Other(List)_____

_____

Do you have any of the following problems? Check all that apply.

- ☐ Blurry Vision
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excessive Tearing/Watering
- ☐ Eye infection
- ☐ Eye Pain or soreness
- ☐ Floaters or spots
- ☐ halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or gritty feeling

Medical History

Date of Last Medical Exam_____

Have you (Yes or no) or a family member(check) experienced or been treated for any of the following? Check all that apply.

AIDS/HIV	○ Yes	○ No	☐ Family
Allergies	○ Yes	○ No	☐ Family
Arthritis	○ Yes	○ No	☐ Family
Asthma	○ Yes	○ No	☐ Family
Blood/Lymph Disorder	○ Yes	○ No	☐ Family
Cancer	○ Yes	○ No	☐ Family
Diabetes	○ Yes	○ No	☐ Family
Type 1☐Type 2☐			
Ears,Nose,Throat	○ Yes	○ No	☐ Family
Gastrointestinal	○ Yes	○ No	☐ Family
Heart Disease	○ Yes	○ No	☐ Family
High Blood Pressure	○ Yes	○ No	☐ Family
High Cholesterol	○ Yes	○ No	☐ Family
Kidney Disease	○ Yes	○ No	☐ Family
Lupus	○ Yes	○ No	☐ Family
Neurological Conditions	○ Yes	○ No	☐ Family
Psychiatric Disorder	○ Yes	○ No	☐ Family
Seizures	○ Yes	○ No	☐ Family
Skin Conditions	○ Yes	○ No	☐ Family
Stroke	○ Yes	○ No	☐ Family
Thyroid Dysfunction	○ Yes	○ No	☐ Family

_____

Current Medications (Prescription and OTC)

_____

_____

_____

_____

Medication or Drug Allergies

_____

_____

_____

Other Allergies(list)_____

_____

_____

_____

Are you pregnant or Nursing?	○ Y	○ N
Do you smoke? #years?_____	○ Y	○ N
Do you drink Alcohol?	○ Y	○ N
Do you use narcotics?	○ Y	○ N

Signature or Parent Signature (if minor)_____Date_____

Name:

FINANCIAL POLICY
Dr. Edward Bancroft, Optometrist

Thank you for choosing our office for your eye care needs. This statement is to inform you of the policies of this office about payments and insurance.

For Patients with Insurance:

Payment for deductibles, co-pay, and non-covered charges are expected at the time of service.

Your insurance is an agreement between you and your insurance carrier. It does not include Dr. Bancroft or this office. It is your responsibility to know your benefits. As a courtesy to you, we will submit your insurance claim on your behalf. This is not a guarantee of payment by your insurance company and final determination of benefits will be made by your insurance company once the claim has been processed. You are ultimately responsible for payment in full.

We cannot be held responsible for any benefit quotes made by your insurance company to our office or for any decisions made by insurance companies in the event of denied or less than expected payment by your insurance company. Payments in excess of estimated amounts will be promptly refunded.

If you assign your insurance benefits to this office we will grant credit for the estimated benefit amount. If your insurance carrier does not remit payment within 45 days, your payment in full will be necessary.

☐ I authorize my insurance carrier to make payments directly to Dr. Bancroft. I authorize Dr. Bancroft to release information concerning the care, advice, treatment, goods and supplies to my insurance company for the purpose of evaluating and administering claims. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____Date_____

Relationship to Insured Self _____

For Patients without insurance:

Payment is expected at the time of service.

For All Patients:

☐ I have read and understand the information in the above financial policy. I understand that I am ultimately responsible for payment in full for all goods and services charged to this account.

Signature or Parent Signature (if minor)_____Date_____

Name:

NOTICE OF PRIVACY PRACTICES
Dr. Edward Bancroft, Optometrist

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATiON. PLEASE REVIEW IT CAREFULLY.

Our commitment at Dr. Bancroft's office is to serve our patient's with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interests, it may be necessary to share information with other Health Care Providers or Business Associates.

During treatment, we may need to send information to labs or contact lens companies.

For payment purposes, we may use the services of a billing service or collection agency.

During heath care operations, we may need to send information to other providers or insurance companies.

We here at Dr. Bancroft's Office are committed to obeying all Federal, State, and Local Laws and Regulations regarding Privacy Practices. If any uses or disclosures, other than the ones listed above are needed, information will only be released with written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided by law.

If you have any question or comments regarding your Protected Health Information, feel free to contact our office at (907)562-2020.

☐ I have read and understand the above Notice of Privacy Practices.

Signature or Parent Signature (if minor)_____Date_____

Clear form