2148 Duluth Hwy Suite 102 Duluth, GA 30097 (770)817-3990 www.betheleyegroup.com

Name _____ SEX: ____Male ____Female
(Last) (First) (M.I.)
Name of Parents (if Child)_____ Name of Spouse_____

Home Address_____

City_____ State_____ Zip Code_____

Patient Nationality: ____White/Caucasian ____Asian ____Black/African-American ____Hispanic
____Native American ____Native Hawaiian/Other Pacific Islander

Patient Status: ____Married ____Single ____Employed ____Student ____Other

Home Phone_____

Cellular Phone_____ Work Phone_____

Name of Company _____ Address of Company_____

Birthday _____ Age_____ Email Address: _____

Nearest Relative or Friend Not living With You _____ Phone_____

Referral _____ Primary Care Physician_____

Insurance **PLEASE COMPLETE THIS AREA WITH PRIMARY CARD HOLDER INFO**

Insurance Plan: _____

Primary Holder's Name:_____
(Last) (First) (M.I.)

Date of Birth:_____/_____/_____ **Sex: M / F**

Primary Holder's Social Security #:_____

Primary's ID #_____

Financial Policy Agreement and Others

- I hereby authorize the undersigned physician to release to insurance carriers any information to process claims regarding services and treatments provided.
- All co-payments and deductible are due at time of service.
- I will be responsible for any and all services in excess of my insurance limits as well as non-covered services.
- I understand if Dr. Cha is not my insurance provider, full payments is due at the time of services, unless prior arrangements have been made. I will submit the insurance claim myself to insurance company for reimbursement.
- I hereby assign payment to the undersigned physician, I understand that I am financially responsible for the non-covered services and if I failed to pay, the account will be referred to credit of bureau and collection service.
- I authorize or Dr. Cha or her employees to leave a message for my family members or answering machine for confirming next appointment
- HIPAA/PRIVACY NOTICE ON DISPLAY IN WAITING AREA IF NEEDED.

Signature (patient or parent if minor)_____**Date**_____

Payment Method: (Please check)

_____**Cash** ↑ _____**Credit Card** ↑ No Personal Check Accepted

Patient History (Please Check) *Date:* _____

OCULAR INFORMATION

Past Ocular History: _____None _____Cataract _____Glaucoma _____Eye Infection
_____Trauma/Foreign Body _____Retinal Tear/Detachment _____Diabetic Retinopathy
_____Amblyopia/Lazy Eye _____Crossed Eye _____ Astigmatism _____Others

Contact Lens History:____No____Yes If Yes, ____Soft____Hard **Spectacle History:**____No____Yes

Eye Surgery History: ____***No*** ____***Yes***

Date		Date	
Date		Date	

MEDICAL INFORMATION /REVIEW OF SYSTEMS

Medical History (Please check)

____None ____Diabetes ____Asthma/emphysema ____Hypertension ____Heart disease
____Stroke____Pregnant ____Menopause ____AIDS ____Arthritis ____Psychiatric ____Dental
____Previous surgery or hospitalization
Medication: ____No ____Yes:_____
Allergies (Drug or food): ____No ____Yes _____

FAMILY HISTORY /SOCIAL HISTORY **(Please specify whether paternal - P, maternal - M, or other)**

Family History: ____ None ____Diabetic( )____Hypertension( )____Glaucoma( )
____Macular degeneration( ) Others:_____
Social History: Do you work at a computer?____Yes____No
If yes, how many hours at the computer per day? _____Hours
____Smoking ____Alcohol ____None

REFFERING (Make sure enter referring physician's information into computer under association)

Doctor's Name_____Doctor's Phone_____

PRIMARY CARE PHYSICIAN (Internist or Family Doctor)

Doctor's Name_____ _____(Same as above)
Phone_____ Address_____

PATIENT ACKNOWLEGEMENT REGARDING DILATION

During the course of your eye examination, it may be necessary to dilate your pupils.
Dilation results in light sensitivity and often an inability to see at close range. These side effects usually last between 3 to 5 hours. If you do not have sunglasses of your own, our office will provide you with disposable sunglasses to help with the light sensitivity.

Patient's Signature Date Assistant's Signature Date