new patient history questionnaire

Thank you for choosing our office for your vision care. In order to provide you with the best care possible, we ask that you answer the questions below. If you prefer, we will be happy to sit down with you to help you complete this form. We are here to assist you!

Name: ____ **Date:** ______________________
(First) (M.I.) (Last)

I prefer to be called: __________________ **Date of Birth:** ___________________ **Age:** ________ **Occupation:** ______________________________

Address: ____ **City:** _________________________ **State:** ________ **Zip:** _______________

Phone (c): (______)______________________ **Phone (h):** (______)______________________ **Phone (w):** (______)________________________

Emergency contact: __________________________________ **Relationship:** _________________________ **Phone:** ___________________________

E-mail:____ **Please check if you do NOT wish to receive eye care updates** □

How did you find us? □ **insurance/provider list** □ **drive/walk by** □ **friend/family** __________________________ □ **other**_________________

Payment is due at the time of service. Payment will be made via: □ **cash** □ **check** □ **charge** □ **insurance** __________________________________

REQUIRED INSURANCE INFORMATION:

EMPLOYMENT STATUS: □ **full-time** □ **part-time** □ **not employed** □ **student, full-time** □ **student, part-time** □ **active duty, military**

IF YOUR INSURANCE POLICY IS NOT IN YOUR NAME, PLEASE PROVIDE THE FOLLOWING:

POLICYHOLDER'S NAME: ____ **POLICYHOLDER'S DATE OF BIRTH:** _______/________/_________

POLICYHOLDER'S ADDRESS: □ **same as above OR fill out below:**

Address: ____ **City:**__________________________ **State:**__________ **Zip:**_____________

PATIENT MEDICAL INFORMATION

Many systemic health conditions, as well as medications, can have an impact on the health of your eyes. Please complete the following information so your doctor can provide you with the most thorough care and evaluation of your eye health.

Have you had any ongoing problems with any of the following systems? Please check (√) all that apply:

_____ **gastrointestinal** _____ **nervous system** _____ **endocrine/glands**

_____ **ears/nose/throat** _____ **urinary tract** _____ **blood/lymph**

_____ **cardiovascular/heart disease** _____ **muscles/bones** _____ **allergic/immunologic**

_____ **respiratory** _____ **integument/skin** _____ **headaches**

_____ **high blood pressure** _____ **cancer** _____ **psychiatric/psychological**

_____ **diabetes (if yes, date of diagnosis:** ____________**)** □ **Type I** □ **Type II**

Please explain: ____

Other health problems: ____

Are you currently taking medication? □ **y** □ **n If yes, please list:** ____

Are you allergic to medication? □ **y** □ **n Please list:** ____ **Do you use cigarettes/tobacco?** □ **y** □ **n**

Name of primary care physician: ____ **Date of last visit:** ___________________________

*** *CONTINUED ON OTHER SIDE* ***

PATIENT'S EYE HISTORY

Date of last eye exam ____ By whom? ____Dilated? □ y □ n

Do you wear glasses? □ y □ n Do you wear contact lenses? □ y □ n If yes, □ soft □ rigid gas permeable/hard □ disposable

Please check any of the following conditions you have/had:

_______ glaucoma ________ retinal detachment __________ dry eyes __________ cataracts __________ macular degeneration

Do you have any other eye conditions or problems? If so, describe ____

Have you had a serious eye injury or eye surgery? If yes, please describe ____

____date?: ______________

Are you using any eye drops (prescription or over-the-counter)? Please list: ____

Please describe any problems with your eyes for which you are seeking treatment today: ____

____

Check all that apply: □ itchy eyes □ stinging/burning □ flashes/floaters □ eyestrain/eye fatigue □ blurry vision □ red eyes

Are you planning to purchase new glasses today? □ yes □ no

Are you considering LASIK / refractive surgery? □ yes, I'd like to discuss it □ no

FAMILY EYE & MEDICAL HISTORY

Please check (√) any conditions that have occurred in your immediate family:

_____	glaucoma	relation_________________	_____	cataracts	relation__________________
_____	macular degeneration	relation_________________	_____	diabetes	relation__________________
_____	retinal detachment	relation_________________	_____	high blood pressure	relation__________________

In order to assist us in processing your insurance claim and to allow for communication with your other health care providers, please read and sign the following:

I authorize Look + See Eye Care to bill my insurance carrier on my behalf. I request that payment of authorized insurance benefits be made to this clinic for any services furnished me by this doctor/clinic. I understand that I am financially responsible for any balance not covered by my insurance carrier, and that a quotation of benefits is not a guarantee of coverage. A copy of this signature is valid as the original. I authorize any holder of medical information about me to release to my medical insurance carrier any information needed to determine the benefits payable for related services for myself and/or my dependents.

Patient/guardian:____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I authorize the release of medical information regarding myself/my dependents and my current condition to my referring, consulting, or treating physicians.

Patient/guardian: ____

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT:

We keep a record of the health care services we provide to you. You may request a copy of your medical record in writing. We will not disclose your record to others unless you direct us to do so or unless legal authorities authorize or compel us to do so. You may request a copy of your medical record or get more information by contacting the Look + See Eye Care Privacy Officer. Our Notice of Privacy Practices is available at the reception desk and is posted in the clinic. The Notice describes in greater detail how your health information may be used or disclosed, and how you can access your information. You are entitled to a copy of this Notice and it is available at your request.

I acknowledge the Notice of Privacy Practices has been offered to me and is readily available in accordance with the Health Insurance Portability and Accountability Act.

Patient/guardian: ____

FOR DOCTOR'S USE ONLY: This form was reviewed by ____ date: ________________________