

# PATIENT INTAKE & HEALTH HISTORY

<b>Patient Legal Name:</b> _____	<b>DOB:</b> _____	<b>Date:</b> _____
<b>Your minimum exam copayment today could be: Routine \$ _____ Medical \$ _____ Contact Fit \$ _____ (if applicable)</b> Final charges will be determined once your exam is completed.		
<b>Please mark your method of payment: Cash: _____ Check: _____ Debit/Credit: _____</b>		

## PATIENT INFORMATION

Preferred Name	Gender	Age
Home Phone #	Home Address	
Cell Phone #		
Email Address	Employer	
SSN (if ins. requires)	Occupation	

## RESPONSIBLE PARTY (if patient is a minor)

Parent/Guardian Full Name	Relationship to Patient
Date of Birth	Primary Phone #
Address	Email Address

## VISION INSURANCE

## MEDICAL INSURANCE

Insurance Carrier	Insurance Carrier
Policy Number	Policy Number
Group Number	Group Number
Secondary (if applicable)	Secondary (if applicable)

## POLICY HOLDER INFORMATION (if different from patient)

Name (as shown on card)	Address
SSN (if ins. requires)	
Date of Birth	Primary Phone #

## PRIMARY CARE INFORMATION

Physician Name	Phone #
<input type="checkbox"/> <b>By checking this box I agree to have my records or diagnosis information shared with my physician.</b>	

## PHARMACY INFORMATION

Pharmacy Name	City & Zip Code
---------------	-----------------

## HIPAA PRIVACY NOTICE

**The HIPAA Policy was available to read during my office visit. \_\_\_\_\_ (patient initials)**  
We do not share your personal health information (PHI) with anyone without your authorization. In case of emergency, please provide information for one individual with whom we may share your medical records.  
**Authorized Individual \_\_\_\_\_ Phone Number \_\_\_\_\_**

## STATEMENT OF FINANCIAL RESPONSIBILITY

In order for my eyecare provider to service my account, or to collect any amounts I may owe, I agree that I may be contacted at any number or address I have provided above or during a previous encounter. I understand that my eye exam and any optional contact lens fitting copayments are due today, and glasses or contact lenses may not be dispensed if those copayments are unpaid. I also understand that fees for services are non-refundable and non-negotiable, and any contact lens prescriptions given are valid for one year per federal law. I furthermore agree to pay any collection expenses incurred to collect any amount I may owe due to non-payment. I understand that I am solely responsible for the cost of all non-covered items, as outlined in detail on my receipt which includes: the specific date of service, description of each procedure/service, and the amount I am responsible for paying out-of-pocket; I certify that I have been informed of all items and cost. I authorize the release of my information for my eyecare provider to file all insurance claims if we are a participating provider for your plan. However, there is no guarantee of benefit information and/or coverage and if my insurance denies payment for any claims submitted, I will be responsible for full payment and can contact my insurance company directly should there be a dispute. My eyecare provider can also supply me with an itemized statement which I may submit to my insurance carrier, should I need to submit for reimbursement. I understand that any follow-up appointments related to a contact lens evaluation are included for three months after the initial fitting, and should there be any follow-up appointments required after the three months have past, I am responsible to pay the professional service fee. Additionally, I know that any optional testing that I have verbally agreed to pay for, is my responsibility to do as such on the date of service. Should I receive a medical examination, I understand that my major medical insurance will be billed and I will be responsible for any deductibles, coinsurance or copayments that may be due.

**I have read and understand the Statement of Financial Responsibility.**

**Signature of Patient (or Parent/Guardian) \_\_\_\_\_ Date \_\_\_\_\_**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Date: \_\_\_\_\_

### PATIENT MEDICAL INFORMATION

Many medical conditions and medications affect the eyes. Please help the doctor by filling out your medical history as completely as possible. Please check all of the conditions that apply to you:

- |                                  |  |                                   |  |                                      |  |
|----------------------------------|--|-----------------------------------|--|--------------------------------------|--|
| <b>Respiratory Issues</b>        | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Hematologic Conditions</b>     | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Ear/Nose/Throat Problems</b>      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Problems                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dental Problems                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>Skin Conditions</b>           | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Allergy/Immunology</b>         | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Neurological Disorder</b>         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eczema                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rosacea                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sjogren's Syndrome                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Headaches                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>Endocrine Disorder</b>        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lupus                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Myasthenia Gravis                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Thyroid Disorder                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Fever/Fatigue/Weight Loss</b>  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Head Injury                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>Gastrointestinal Issues</b>   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Musculoskeletal Conditions</b> | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heartburn                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Kidney/Bladder Problems</b>       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>Cardiovascular Conditions</b> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Psychiatric Disorder</b>       | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Sexually Transmitted Diseases</b> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anxiety                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Cancer</b>                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Failure                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Depression                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Surgical Operations</b>           | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Have you previously had any eye injuries, eye surgeries or eye diseases?  Yes  No If yes, please describe: \_\_\_\_\_

Have you experienced any floaters, flashes of light, burning, itching, redness, dryness, double vision, unusual blurry vision, frequent styes/chalazions, or excessive tearing/watering?  Yes  No If yes, please describe: \_\_\_\_\_

Do you have light sensitivity or issues with glare while outdoors or driving?  Yes  No  Sometimes

Do you have issues with glare or have eye fatigue while on a computer?  Yes  No  Sometimes

Are you currently being treated for any other medical conditions?  Yes  No If yes, please describe: \_\_\_\_\_

Please list any medications you are currently taking (Including hormones, vitamins, birth control, aspirin, other anti-inflammatory, eye drops, etc.): \_\_\_\_\_  None

Date of last general health exam: \_\_\_\_\_ Date of last eye exam: \_\_\_\_\_ Previous eye care provider: \_\_\_\_\_

Are you currently pregnant or nursing?  Yes  No

Do you smoke or use tobacco?  Yes  No \_\_\_Less than 1 Pack a Day \_\_\_1-2 Packs a Day \_\_\_2 Packs a Day

Do you drink alcohol?  Yes  No \_\_\_Social \_\_\_1-2 Drinks Daily \_\_\_Above Average Use \_\_\_Dependence

Are you allergic to any medications?  Yes  No If yes, please list: \_\_\_\_\_

### CONTACT LENS INFORMATION

Do you currently wear contact lenses?  Yes  No If yes, please list the brand: \_\_\_\_\_

How many hours a day do you wear contacts? \_\_\_\_\_ How often do you throw away your lenses? \_\_\_\_\_

Do your eyes feel dry while wearing contacts?  Yes  No What do you use to clean your lenses? \_\_\_\_\_

### FAMILY HISTORY

Has anyone in your family had any of the following illnesses?

- |                       |  |                     |
|-----------------------|--|---------------------|
| Blindness*            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship: _____ |
| Cancer*               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship: _____ |
| Cataract              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship: _____ |
| Color Blindness*      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship: _____ |
| Diabetes*             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship: _____ |
| Glaucoma*             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship: _____ |
| Heart Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship: _____ |
| High Blood Pressure*  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship: _____ |
| Lazy Eye*             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship: _____ |
| Macular Degeneration* | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship: _____ |
| Respiratory Disease   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship: _____ |
| Retinal Detachment*   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship: _____ |

\*Additional testing may be covered through your medical insurance.

### For Office Use Only

L	FDT	PHOTO
---	-----	-------

A	O
---	---