PATIENT INFORMATION QUESTIONNAIRE

Last Name: _____ **First**_____ **M.I.**___ **Today's Date:** _____
Nickname:_____ **(Gender: M F)** **Occupation:** _____
Address: _____ **Employer:** _____
City: _____ **State:** _____ **Zip:** _____ **Home Phone:** _____
Date of Birth: ___/___/___ **SSN**_____-_____-_____ **Cell Phone:**_____
Parent/Guardian (if applicable)_____ **Email:**_____
Primary Care physician: _____ **Last Eye Exam:** _____
Preferred Pharmacy: _____ **Referred by:** _____

HIPAA Notice and Acknowledgment
I acknowledge that I have been provided the HIPAA Notice of Privacy Practice. __Yes __No

Chief Complaint: What is your primary reason for this visit?

_____

Are you experiencing any of the following ocular or visual symptoms? (Check all that apply)

Blurred Vision ___	Light Sensitivity ___	Reduced Night Vision ___
Burning Eyes ___	Itchy, Watery Eyes ___	Reduced Side Vision ___
Excessive Tearing ___	Dry, Gritty Feeling ___	Halos around Lights ___
Noticeable Redness ___	Pain or Discomfort ___	Flashes or Flickers ___
Double Vision ___	New Floaters/Spots ___	Loss of Vision ___

Have you ever been diagnosed with, or treated for, any of the following ocular conditions?

Retinal Detachment ___	Ocular Infections ___	Lazy or Turned Eye ___
Cataracts ___	Glaucoma ___	Styes, Inflamed Lids ___
Macular Degeneration ___	Disease of Retina ___	

Do you now wear glasses? _____ If so, how old are they? _____
How is your vision with them? _____
What type? Readers ___ Distance ___ Bifocal ___ Trifocal ___ Progressive ___

ATTENTION CONTACT LENS PATIENTS:
A contact lens fitting is a professional service separate from the routine vision exam. The fitting includes the trial lenses and any follow-up appointments to provide you with a contact lens prescription. By signing below, you acknowledge that you can use your insurance benefits to cover the contact lens fitting *with applicable copay*, OR you will pay for the contact lens fitting at the time of service.

Signature (patient/ responsible party)_____ Date_____
Do you currently wear contact lenses?_____ What type/brand?_____ Hours per day?_____

Do you use a computer?_____ How many hours per day? _____
Any previous surgeries or injuries to your eyes?_____ If so, please describe_____
_____
Using any ocular medicines? _____ Please list if known: _____

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Medical History:

Do you have any allergies to medicines?_____ If so, please list: _____

Are you taking any Rx or OTC medicines?_____ If so, please list: _____

_____

Any previous injuries, surgeries, or hospitalizations? _____

_____

Are you pregnant or nursing? _____ If pregnant, list due date:_____

Have you been diagnosed with or treated for any of the following problems? (Check all that apply)

Allergy Food ____ Seasonal____

Cardiovascular
Heart Problems ____
High Blood Pressure ____

Constitutional
Fever ____
Weight Gain ____
Weight Loss ____
Dizziness/Fainting ____

Endocrine
Diabetes ____
Thyroid Disorder ____
Elevated Cholesterol ____

Gastrointestinal
Gastrointestinal Disorder ____
Hepatitis ____
Gallbladder ____
Ulcers ____

Genitourinary
Bladder Infection ____
Kidney Stones ____

Cranial/Facial
Chronic Cough ____
Dry Mouth ____
Sinus Infection ____
Ear Infection ____
Hearing Loss ____

Hematologic/Lymphatic
Anemia ____
Clotting/Bleeding Disorders ____

Immunologic
HIV/AIDS ____
Syphilis ____
Lupus ____
Mononucleosis ____
Shingles ____

Musculoskeletal
Arthritis ____
Joint Pain ____
Muscle Pain ____

Neurological
Headaches ____
Migraines ____
Seizures ____
Bell's Palsy ____
CP/MS/MD/MG ____

Psychiatric
Depression ____
ADD/ADHD ____
Alzheimer's/Dementia___

Respiratory
Asthma ____
Chronic Bronchitis ____
Emphysema, COPD ____
Tuberculosis ____

Social History: Do you drive? ____Yes ____No If yes, are you having any visual difficulties? _____

Do you use tobacco products? ____Yes ____No If so, how often? _____

Do you use alcohol? ____Yes ____No If so, how often? _____

Do you have a history of drug or alcohol abuse? ____Yes ____No If yes, how long? _____

Have you ever been exposed to HIV or other sexually transmitted diseases? ____Yes ____No

Family Medical History: In your immediate family, is there any history of the following conditions?

Blindness: Injury___ Disease____ Relationship: _____
Turned or Lazy Eyes ____ Relationship: _____
Cataracts ____ Relationship: _____
Glaucoma ____ Relationship: _____
Macular Degeneration ____ Relationship: _____
Retinal Detach/Disease ____ Relationship: _____
Arthritis ____ Relationship: _____
Cancer ____ Relationship: _____
Diabetes ____ Relationship: _____
Heart Disease ____ Relationship: _____
High Blood Pressure ____ Relationship: _____
Kidney Disease ____ Relationship: _____
Lupus ____ Relationship: _____
Thyroid Disease ____ Relationship: _____

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Patient Insurance Information

Vision Plan being billed today:

Primary's Name: _____ Primary's DOB: _____
Name of Plan or Insurance: _____ Primary's Employer: _____
Member ID or SSN Number: _____ Group Number: _____

Medical Insurance being billed today:

Primary's Name: _____ Primary's DOB: _____
Name of Plan or Insurance: _____ Primary's Employer: _____
Member ID or SSN Number: _____ Group Number: _____

Please provide the front desk with the most current copy of your medical insurance card.

Acknowledgements and Signature

1. I understand that this serves as my signature on file for all insurance and records release purposes.
2. I understand that there is a return check fee of $50. Return check fees are assessed on any bad/returned check including ACH payment plans. $50 will be assessed on each occurrence. Return check fees may be withdrawn automatically from your bank as soon as funds are available.
3. There is a service fee of $50 for any missed appointments or late cancellations (less than 24 hrs).

Warranty Policy

We want you to love your new glasses! We offer a one-year warranty on all frames purchased in our office (loss, theft and normal wear/tear are not included). Purchase of anti-reflective coating adds a one-year, one-time replacement for scratches on lenses (improper care of lenses is not included). There will be a $20 processing fee for these.

Order Cancellation Policy

Once an order has been paid for, it is submitted to the lab immediately and electronically, therefore a 20% charge may be assessed for any canceled orders regardless of reason or time. Jobs started longer than 24 hours may not be canceled.

Information Disclosure

I hereby authorize my health information to be released to:

Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____

I acknowledge that the health and insurance information I have provided above is true and correct to the best of my ability. I authorize payment of any vision or medical benefits I may be eligible for directly to Eye Care Professionals. **I agree that if my employer, insurance carrier, or plan sponsor denies payment to all or any part of my claim, I will be financially responsible for all outstanding charges**. I acknowledge that authorization obtained at the time of service does not guarantee payment, and any services not covered by insurance will be billed to me. In the event it becomes necessary to place any unpaid balances I am responsible for in collection, I agree to pay any collection fees, reasonable attorney fees, filing fees, and other costs the court determines are proper. I have read the conditions of service, and as the Patient or the Patient's Authorized Representative I hereby accept these terms.

Signature of Patient or _____ **Date**: _____
Responsible Party