EYELAND PATIENT HISTORY QUESTIONNAIRE

Title _____ Last Name _____ First Name _____ MI_____ Date_____
(Mr. Mrs. Ms. Dr.)

Name you wish to be called _____ Email _____

Home Address _____ City _____ State _____ Zip_____

Age _____ Date of Birth _____ SSN _____

Employer/School _____ Occupation _____ Cell _____

Name of Parent, Legal Guardian, or Spouse _____ Home _____

Name of Family members whome we have provided care _____ Work _____

Insurance Company _____ ID# _____

Subscriber Name _____ Relationship to Patient _____

Date of Birth _____

PLEASE CHECK ALL THAT APPLY (Unchecked boxes will be accepted as a negative answer)

FAMILY MEDICAL HISTORY

- ☐ Arthritis
- ☐ Blindness
- ☐ Cancer
- ☐ Cataracts
- ☐ Diabetes
- ☐ Eye Disease
- ☐ Heart Disease
- ☐ Glaucoma
- ☐ High Blood Pressure
- ☐ Lazy Eye
- ☐ Macular Degeneration
- ☐ Color Blindness
- ☐ Other Explain Below
- ☐ Retinal Detachment

PATIENT'S MEDICAL HISTORY

- ☐ Head Injury
- ☐ Headaches
- ☐ Sinus Problems
- ☐ Skin Condition
- ☐ Diabetes
- ☐ Surgical Operations
- ☐ Arthritis
- ☐ Drug Allergies
- ☐ Thyroid Disorder
- ☐ Bleeding Disorder
- ☐ Emphysema
- ☐ Drug Use
- ☐ Cancer
- ☐ Heart Problems
- ☐ Alcohol Use
- ☐ Gastrointestinal
- ☐ High Blood Presure
- ☐ Tobacco Use
- ☐ Ear/Nose/Throat
- ☐ HIV
- ☐ Endocrine
- ☐ Cardiovascular
- ☐ Migraines
- ☐ Mental
- ☐ Musculoskeletal
- ☐ Nervous
- ☐ Allergic/Immunologic
- ☐ Dental Problems
- ☐ Genitourinary
- ☐ Pregnant/Nursing
- ☐ Pre/Post Natal Problems

Other Conditions

_____

_____

Please list any medications you are now taking, including birth control, hormones, vitamins or over the counter medications:

_____

_____

EYE HISTORY

☐ Eye Injury ☐ Flashes/Floaters ☐ Double Vision ☐ Eye Surgery ☐ Loss of Vision

☐ Macular Degeneration ☐ Cataracts ☐ Glaucoma ☐ Dry Eye ☐ Blurred Vision ☐ Lazy Eye

Last Eyecare Provider _____ Date of Last Eye Exam _____

Are you currently having vision problems? ☐ Yes ☐ No Any eye drops?_____

If yes please explain _____

Do you wear glasses? ☐ Yes ☐ No How old are they? _____ Are they bifocals? _____

Are your glasses for ☐ Reading ☐ Distance ☐ Both

Have you ever worn contact lenses? ☐ Yes ☐ No If yes, when where they prescribed? _____

Are you interested in wearing contacts? ☐ Yes ☐ No

Primary Care Physician _____ Pediatrician _____

SOCIAL HISTORY

Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving ☐ Yes ☐ No

If yes, please describe _____

Do you use tobacco products? ☐ Yes ☐ No _____

Do you drink alcohol? ☐ Yes ☐ No _____

Do you use illegal drugs? ☐ Yes ☐ No _____

Have you ever been exposed or infected with ☐ Hepatitis ☐ HIV

If patient is under 18 please complete:

Any prenatal, perinatal, or postnatal problems? ☐ Yes ☐ No _____

Any developmental problems? ☐ Yes ☐ No _____

Do you have any concerns about your child's school performance?

_____

Payment for all services and products is the responsibility of the patient.

I agree to pay all copays, deductibles, co-insurances and non covered services as determined by my insurance company.

I understand there is a returned check fee applied to every returned check.

I agree to pay an additional collection fee for all accounts not paid in the time stated on the final monthly statement.

I authorize the release of medical information concerning my illness and treatment by Eyeland to my insurance company.

I also authorize release of my personal medical information to any doctor whom I may be referred to.

I understand verification of eligibility is not a guarantee of payment as stated by my insurance company.

I authorize payment of my insurance benefits to Eyeland

Signature of patient or legal guardian Today's Date

Reviewed by Dr. _____ Date: _____

Dr. _____ Date: _____

Dr. _____ Date: _____

We will file all insurance forms if Eyeland is a participating provider for your plan.

We will supply you with an itemized statement which you may submit to your insurance carrier.

PAYMENT IN FULL IS REQUIRED AT TIME OF SERVICE.