Medical History Questionnaire

Name: _____ Today's Date: _____
Birth Date: _____ Current Primary Care Physician: _____
Height: _____ Weight: _____ Last Medical Exam: _____

Medical History:

List any allergies to medications or substances: _____
List any medications you are taking (prescription or otherwise):
_____
List any reasons for recent hospitalizations or surgery: _____
Review of Systems: Do you currently, or have you ever had, any problems in the following areas:

System	Yes	No
Eyes		
Loss of vision	___	___
Blurred vision	___	___
Double vision	___	___
Redness	___	___
Burning	___	___
Itching	___	___
Light Sensitive	___	___
Excess Tearing/Watering	___	___
Eye injury	___	___
Eye surgery	___	___
Floaters/Flashes	___	___
Glare/Halos	___	___
Crossed or lazy eye	___	___
Cataracts	___	___
Glaucoma	___	___
Eye pain/soreness	___	___
Retinal disease	___	___
Endocrine		
Thyroid	___	___
Diabetes	___	___
Bones/Joints/Muscles		
Rheumatoid arthritis	___	___
Joint/Back Pain	___	___
Hematologic		
Anemia	___	___
Vascular/Heart		
High Blood Pressure	___	___
Heart Disease	___	___

System	Yes	No
Cancer	___	___
Type: _____		
Neurological		
Headaches	___	___
Migraines	___	___
Seizures	___	___
Respiratory		
Asthma	___	___
COPD/Emph	___	___
Skin Disorder	___	___
Psychiatric	___	___
IBS/Crohn's	___	___
Ear/Nose/Throat/Mouth	___	___
Allergies/Hay fever	___	___
Genitourinary		
Kidney/Bladder	___	___
Genital	___	___
Sleep Disorders		
Sleep Apnea	___	___
Social History		
Use of tobacco products	___	___
Use of illegal drugs	___	___
Alcohol consumption	___	___
(how much) _____		

Have you ever been exposed or infected with (circle)
Gonorrhea Hepatitis HIV Syphilis

Family History

Ocular Condition	Yes	No
Blindness	___	___
Glaucoma	___	___
Macular Degeneration	___	___
Retinal Detachment	___	___

Systemic Condition	Yes	No
Diabetes	___	___
High Blood Pressure	___	___
Cancer	___	___
Heart Disease	___	___

By signing this I consent to treatment for myself and/or on behalf of the minor to whom this information pertains. I give permission for the doctor to examine, diagnose and initiate treatment as deemed appropriate. I further attest that I am the parent or Legal Guardian of Minor and have the authority to authorize care and treatment:

Patient/Guardian Signature _____

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please *print* name of Patient Please *sign* Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

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OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe) _____

Signature of Privacy Officer _____

Patient Information

Name: _____ Date: _____ Birth Date: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Current Primary Care Doctor: _____

Gender: Male___ Female___ Other___ Last Four of Social Security #: _____ Marital Status: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Email Address: _____

Employment Status: Yes - Full Time Part-Time No Retired

Employer: _____ Occupation: _____

Responsible Party Information

Person Responsible for Account _____ Relationship _____

Last Four Digits of Social Security# _____ D.O.B. _____

Address (if different from patient) _____

_____

Financial Information

I hereby give my consent to Shippee Family Eye Care or any doctors at this location to provide eye care services to myself and/or any party I am responsible for. I understand that I am ultimately responsible, regardless of insurance status.

Signed: _____ Date: _____

Information Authorization

I authorize use of this signature for all my insurance submissions. I authorize payment of benefits directly to my doctor. I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signed: _____ Date: _____

Medicare Waiver

I understand that Medicare does not pay for service code 92015 "Refraction," I will be responsible for this charge of $40.00. I understand that Medicare does not pay for glasses except for the first pair following Cataract surgery.

Signed: _____ Date: _____