

Medical History Questionnaire

The information in this confidential personal history form is critical to the evaluation of your vision.

Patient History Full Name _____ Date _____
 Nickname _____ Age _____ DOB _____ SS# _____
 Address _____ City _____ Zip _____
 Home Phone(____) _____ Cell Phone(____) _____ Other Phone (____) _____
 Employer _____ Work Phone(____) _____
 E-mail _____ Sex (circle) Male / Female Occupation _____
 Married Divorced Widowed Separated Single Minor Partnered
 Person Responsible for Account _____ Relationship to Patient _____
 Insurance that covers vision care? Yes No Eye Med BCBS Medicare VCP Compbenefits
 Superior Vision New Southland Other _____
 Subscriber's Name _____ DOB _____ SS# _____
 Name of carrier or group # _____ Identification # _____
 Spouse's Name _____ DOB _____ Phone # (____) _____

IN CASE OF EMERGENCY, CONTACT (*Specify someone who does not live in your household.*)
 Name _____ Relationship _____
 Home (____) _____ Cell (____) _____ Work (____) _____ Ext _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

Last Eye Doctor: _____ Last Eye Exam: _____
 Current Medical Doctor: _____ Last Medical Exam: _____

Medications	Allergies

Do you wear contact lenses? Yes No What type? _____
 Have you had problems wearing contacts? Yes No Describe _____
 Have you been told you cannot wear them? Yes No Are you interested in trying contacts? Yes No
 Do you wear glasses? Yes No How old is your present pair of glasses? _____
 Have you had refractive surgery? Yes No
 At work: Do you perform fine or close-up work? Yes No
 Are you outdoors all or part of the time? Yes No
 Is safety protection a concern at work? Yes No
 Do you have trouble reading signs when driving at night? Yes No
 Are you bothered by the glare from: Overhead lighting? Computer screen? Oncoming headlights at night?

Do you experience any of the following discomforts?

<input type="checkbox"/> Headaches?	<input type="checkbox"/> Light sensitivity?	<input type="checkbox"/> Double vision?	<input type="checkbox"/> Sandy or gritty feeling?
<input type="checkbox"/> Migraines?	<input type="checkbox"/> Blurred vision?	<input type="checkbox"/> Redness?	<input type="checkbox"/> Flashes/floaters in vision?
<input type="checkbox"/> Seizures?	<input type="checkbox"/> Dryness?	<input type="checkbox"/> Burning?	<input type="checkbox"/> Foreign body sensation?
<input type="checkbox"/> Eyestrain?	<input type="checkbox"/> Excess tearing/watering?	<input type="checkbox"/> Itching?	<input type="checkbox"/> Chronic eye infection?

Please complete both pages of this document.

Continued...

Medical History: Do you currently, or have you or any of your relatives ever had any problems in the following areas:

Ocular Disease/Condition	Self	Family	None	Relationship	Condition	Self	Family	None	Relationship
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Systemic Disease/Condition	Self	Family	None	Relationship	Condition	Self	Family	None	Relationship
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other				_____					_____

Payment Policy

Charges for initial visit, whether examination or emergency, are payable in full at the time services are rendered unless insurance information is provided. As a courtesy, we will file an insurance claim and accept payment directly from your insurance company when applicable. However, YOU are responsible for any balance not covered by your insurance plan. Please consult with our Office Manager concerning a need for partial payment prior to treatment. Fees not paid within sixty (60) days are subject to a past-due billing charge of \$2.00 per month or 1.5% per month, whichever is greater. All costs of collection by attorney/collection companies will be your responsibility as well.

Release

I authorize Dr. Martha Wright to perform diagnostic procedures and treatment as may be necessary for proper eye care. I hereby authorize payment of insurance benefits directly to Dr. Wright, otherwise payable to me. I authorize release of any information concerning my (or my child's) health care, advice and treatment to my insurance company relating to any claims on my (or my child's) behalf. I understand that my insurance carrier or payer of my benefits may pay less than the actual bill for services. I understand that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid in whole or in part by my insurance carrier.

Patient/Guardian Signature: _____ Date: _____

Our Notice of Privacy Practices

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our website.

Complaints

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address or fax shown on the attached Notice. If you prefer, you can discuss your complaint in person or by phone.

If you want more information about or privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of the Notice.

Acknowledgement of Receipt

I acknowledge that I received or read a copy of *Dr. Martha Wright's* Notice of Privacy Practices.

Patient Name (*please print*): _____

Signature: _____ Date: _____