Medical History Questionnaire

Today's Date:____/____/____

Name:_____ **Date of Birth:**_____ **Social Security #:**____-____-____

Mobile#:(**)**_____ **Home #: (** **)**_____ **Work #:(** **)**_____ **Preference:** Mobile / Home/ Work

Occupation:_____ **Last Eye Exam:**_____ **Email:**_____

Family Doctor: _____ **Family Doctor Phone Number:** _____

Parent/Guardian Name: _____ **Phone Number:** _____

Reason for today's visit? _____

Do you have any allergies to medications or environmental allergies? □ No □ Yes **If yes, please list:**

_____

Are you currently taking any medications? □ No □ Yes **If yes, please list:** _____

_____

_____

Have you ever had any EYE injury or surgery? If yes, list: _____ **Surgeon:** _____

Do you use one of the following: Please circle- computer, phone, and tablet? If so, how many hours per day: _____

Are you pregnant and/or nursing? □ No □ Yes **Do you wear contacts?** □ No □ Yes **If so, what brand?** _____

Review of Systems **Do you currently, or have you ever had any problems in the following areas: If none, check this box** □ NONE

Constitutional: □ Fever □ Weight loss □ Weight gain □ Head Trauma	**Cardiovascular:** □ Stroke □High Blood Pressure
Ears, Nose, Mouth, Throat:□Sinus Congestion □Post-Nasal Drip □Dry mouth	**Respiratory:** □ Asthma □ Chronic bronchitis □ Emphysema
Gastrointestinal: □ Crohn's □ Colitis □ Ulcer □ IBS □ Hernia	**Genitourinary:** □ Kidneys □ Bladder □ Frequent urination
Bones/Joints/Muscles: □ Arthritis □ Muscle Pain □ Joint Pain	**Integumentary:** □ Eczema □ Rosacea □ Psoriasis □ Lupus
Neurological: □ Headaches □ Migraines □ Seizures □ Multiple Sclerosis	**Psychiatric:** □ Bipolar □ Depression □ ADHD □ Schizophrenia
Endocrine: □ Thyroid □ Diabetes □ Gestational Diabetes	**Lymphatic / Hematologic:** □ Anemia □ Bleeding Problems
Allergic / Immunologic: □ Aids □ Infectious disease	**Eyes:** □ Double Vision □ Floaters □ Flashes □ Dryness

Ocular History □ None

- □ Age-related macular degeneration
- □ Amblyopia (lazy eye)
- □ Cataract
- □ Glaucoma
- □ History of laser surgery
- □ Ocular Hypertension (high pressures)
- □ Retinal detachment
- □ Retinal tear / hole
- □ Tear film insufficiency (dry eyes)
- □ Vitreous flashes
- □ Vitreous floaters

Personal Medical History □ None

- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Carotid Artery Occlusion
- □ Congestive Heart Failure
- □ Dementia
- □ Diabetes Mellitus Type 1
- □ Diabetes Mellitus Type 2
- □ High Cholesterol
- □ High Blood Pressure
- □ Cancer, What kind? _____
- □ Other: _____

Family History □ None

**** If yes, please indicate WHO****

- □ Macular degeneration_____
- □ Amblyopia (lazy eye)_____
- □ Blindness_____
- □ Cataract_____
- □ Glaucoma_____
- □ Arthritis_____
- □ Cancer_____
- □ Diabetes Mellitus_____
- □ Thyroid disorder_____
- □ High Cholesterol_____
- □ High blood pressure_____
- □ Family history unknown/Adopted

Social History:

Do you use caffeine (coffee, soda)? □ No □ Yes **IF YES,** □ Light □ Moderate □ Heavy

Do you use illegal drugs? □ No □ Yes

Do you drink alcohol? □ No □ Yes **IF YES,** □ Former □ Light □ Moderate □ Heavy

Do you use tobacco products? □ No □ Yes **IF YES,** □ Current every day smoker □ Former smoker □ Light tobacco smoker □ Chewing

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Individual's Name: _____
Last First Middle

Home Address: _____
Address City State Zip

Home Telephone: _____ **Date of Birth** _____

Email: _____

By my signature below, I hereby consent to the use or disclosure of my health information in order that Optical One, Inc. and the Independent Optometrists on location may provide treatment, obtain payment for treatment or carry out its health care operations. I understand that this consent only gives Optical One, Inc. and the Independent Optometrists on location a more limited right to use any highly confidential health information contained in psychotherapy notes or about: (1) mental health and developmental disabilities; (2) substance abuse; (3) HIV/AIDS testing; (4) genetic testing; (5) child abuse and neglect; or (6) communicable diseases. For purposes of this consent, health information includes any and all information relating to health care services provided to me by Optical One, Inc. and the Independent Optometrists on location, including, without limitation, information relating to services provided to me prior to the date of this consent.

I understand that Optical One, Inc. and the Independent Optometrists on location, have a Notice of Privacy Practices that explains, among other things, the definitions of treatment, payment and health care operations and the types of uses or disclosures that Optical One, Inc. and the Independent Optometrists on location can make if I sign this consent. I understand that I have the right to review the Notice before I sign this consent. I further understand that Optical One, Inc. and the Independent Optometrists on location may change the terms of the Notice from time to time, but that any such changes will be in accordance with all federal and state laws governing the use and disclosure of health information, including any highly confidential health information. I understand that I may contact the Privacy Office, at the address listed below, to obtain a revised version of the Notice at any time.

I understand that I may at any time submit a request in writing to the Privacy Office, at the address listed below, that Optical One, Inc. and the Independent Optometrists on location restrict how my health information is used or disclosed to carry out treatment, payment or health care operations. Optical One, Inc. and the Independent Optometrists on location are not required to agree to my requested restriction. In the event that Optical One, Inc. and the Independent Optometrists on location do agree to the requested restriction, however, the restriction will be binding on Optical One, Inc. and the Independent Optometrists on location.

I understand that this consent will remain in effect until I provide a written notice of revocation to the Privacy Office at the address listed below. The revocation will be effective immediately upon the Optical One, Inc. and the Independent Optometrists on location receipt of my written notice, except that the revocation will not have any effect on any actions Optical One, Inc. and the Independent Optometrists on location took before it received my written notice.

The address of the Privacy Office is as follows: Privacy Office, Optical One, Inc. 5233 Coldwater Rd., Fort Wayne, IN 46825. (260)482-1555.

I understand that if I refuse to sign this consent or if I revoke this consent in the future that Optical One Inc. and the Independent Optometrists on location may not provide any treatment to me or arrange for treatment on my behalf, except under certain emergencies or if otherwise required by law.

_____ _____
Signature of Patient (or Personal Representative) Date

_____

Patient Financial Responsibility

Contact Lens Policy

If you choose to go with a contact lens exam you will be responsible for the contact lens fit*. This is a non-covered service with most insurance companies. If you choose not to do a contact lens exam today, you have 3 months to return from the original exam date for a contact lens completion. If you decide to come back after 3 months, there will be an additional charge. *Contact lens fit includes; fitting of contacts, trial pair of contacts, follow up visits, and insertion & removal class. **If you purchase any contact lenses from us we CANNOT return or exchange opened or damaged boxes.

Dilation Information

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the optometrist to get a better view of the inside of your eye. Dilating drops cause vision to blur for a length of time which varies from person to person and may make bright lights bothersome. IT IS NOT POSSIBLE for your optometrist to predict how much your vision may be affected. Because driving may be difficult immediately after an examination, you may want to consider making arrangements to be driven home. Please be aware as well, if you do not have a secured driver and do not feel comfortable driving after dilation, you may schedule to come back at a later date for the sole purpose of dilation. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. **This is extremely rare and treatable with immediate medical attention!**

Patients do reserve the right to refuse any test or diagnostic procedure recommended. If a patient refuses, however, he or she resumes all of the risk for the doctor not detecting, and thereby treating in a timely manner, any serious eye conditions, including retinal detachments, hemorrhages, growths, etc.

Insurance Policy/ Out-of-Network Authorization

We, at Soulier Eye Care Associates, try our very best to verify eligibility on or before date of service within our offices. Ultimately, it is your (patient/guardian) responsibility to know your eligibility for in-network and out-of-network coverage.

Unfortunately, VSP/Metlife, Employee Plans and AGA (Automated Group Administration) are out out-of-network, and will no longer release that information to us (Soulier Eyecare). Some plans under the previously mentioned insurances, may have out-of-network benefits. Meaning, they will still cover a small portion of the exam or materials.

Despite our best efforts, we still occasionally have claims deny because of information that was not disclosed to us. If the information we have at date of service is incorrect, we will then send a bill to the responsible party.

For insurance purposes, please fill out the following to the best of your ability!

Primary Cardholder's Name:_____ Date of Birth:_____

Primary Cardholder's Last 4 of SSN:_____

Patient Name_____ Date of Birth:_____

Patient Relationship To Insured (please circle): Self / Spouse / Child

Please sign below to acknowledge that you have read and understood all of the above statements:

Patient/Guardian (Print):_____ **Date:**_____

Patient/Guardian Signature:_____