Medical History Form

Name: _____ Today's Date: _____

Preferred Name: _____ Date of Birth: _____

Address: _____ Occupation: _____

City/Zip: _____ Employer: _____

Phone: _____ Hobbies: _____

Type: _ Cell _Work _Home _OK to text Last 4 of Social Security: _____

Email:_____ ☐ **I would like email paperless billing**

How did you hear about our office: _____

What is your reason for today's eye exam? Please mark all that apply

____ Blur at Distance	____ Red Eyes	____ Eye Pain/Discomfort
____ Blur at Near	____ Flashes/Spots	____ Itching/Allergies
____ Computer Strain	____ Glaucoma	____ Contact Lenses
____ Double Vision	____ Headache	____ Other

Have you had any eye injuries? ____ No ____Yes Please Explain: _____

Have you had any eye surgeries? ____ No ____ Yes Please Explain:_____

Are you interested in information on Laser Eye Surgery? ____No ____ Yes

Medical History

Do you have, or have you been treated for:

____ Diabetes	____ Arthritis/Joint Pain	____ Breathing Problems
____ High Blood Pressure	____ Kidney/Urinary	____ Depression/Anxiety
____ Heart Disease	____ MS	____ Sinus/Allergy
____ Stroke	____ Cancer	____ Skin Condition
____ High Cholesterol	____ STD	____ Dry Eyes
____ Hearing Loss	____ Thyroid/Glands	____ Styes/Chalazion
____ Weight Loss/Gain	____ Double Vision	____ Headache/Migraines
____ Eye Pain/Itching	____ Loss of Vision	____ Other

Do you have any allergies? ____ No ____ Yes If yes, please explain:_____

Are you pregnant? ____ No ____ Yes

Do you use tobacco products? ____ No ____ Yes Frequency/amount? _____

Do you drink alcohol? ____ No ____ Yes Frequency/amount?_____

Do you have a history of recreational drug use? ____ No ____ Yes

Do you take any medications? ____ No ____ Yes If yes, please list: _____

_____

Do you have any parents/grandparents with any of the following medical conditions?

_____ Diabetes	_____ Glaucoma
_____ High Blood Pressure	_____ Macular degeneration

Insurance Information

Please present your insurance cards before exam

Medical Insurance Provider: _____
Policy Holder Name: _____
Policy Holder DOB: _____
Last 4 of Social Security: _____

Vision Insurance Provider: _____
Policy Holder Name: _____
Policy Holder DOB: _____
Last 4 of Social Security: _____

Acknowledgment of Financial Responsibility and HIPAA Privacy Act

- I understand that I am financially responsible for payment of any services provided by Advanced Family Eyecare, including services not covered by my insurance, as well as co-pays, deductibles, and co-insurance.
- I request that payment of authorization insurance benefits, including Medicare, be made to Advanced Family Eyecare for services furnished to me by any provider employed by this clinic.
- I authorize Advanced Family Eyecare to release any medical information to other providers who are involved in my treatment.
- This authorization and assignment will remain in effect until revoked by me in writing.
- I acknowledge that I've been offered a copy of my glasses/contact lens prescription.
- I acknowledge that I've received a copy of Advanced Family Eyecare Notice of Policy Practices.

X_____ _____

Signature of patient or guardian of minor Date

Option of Additional OCT Screening

OCT (Optical Coherence Tomography) is the newest and most advanced technology for Retina Screenings and allows for the earliest possible detection of any pathology.

It is highly recommended for patients with a family history of:

Age Related Macular Degeneration
Ocular Melanoma
Glaucoma
Diabetes

This screening test is $39 and is not covered by insurance.

☐ **Yes, I would like the OCT Screening** ☐ **Decline**