PATIENT HISTORY QUESTIONNAIRE

Date ______________

Last name ________________________ First name ________________________ MI______

Address ________________________ City________________ State________ Zip____________

Work phone ( ) ____________________ Home phone ( )____________________ SSN______-______-_______

DOB ____________________ Occupation ________________________ Employer ________________________

Emergency contact name________________ Phone number ( )______________ / Mobile ( )______________

Date of last eye exam______________ Dilated? Yes / No Marital Status: ___S ___M ___W ___D

E-mail:________________________________ Referred by________________________________

PHONE BOOK_____ MINT MAGAZINE_____
CORPORATE CARE_____

Medical Information

What is your general health? ________________________________ Date of last tetanus shot ____________

Do you have problems with any of these systems? **(Please circle yes or no.)**

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/lymph	Yes/No
Cardiovascular	Yes/No	Muscles/bones	Yes/No	Allergic/immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain ____

Diabetes Yes/No Type________________________ Date of diagnosis ________________

Allergies to medication? Yes/No Which? ______________ Reactions? ________________

Other health problems ____

Current medication(s) ____ Check if none ☐

Have you had any operations? Yes/No Kind? ________________________ When?______________

Name of family doctor ________________________________ Date of last visit ________________

Family History

High blood pressure	Yes/No	Relation ____________	Macular degeneration	Yes/No	Relation ____________
Diabetes	Yes/No	Relation ____________	Retinal detachment	Yes/No	Relation ____________
Glaucoma	Yes/No	Relation ____________	Cataracts	Yes/No	Relation ____________

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What Kind?________________________________

Have you had any eye operations? Yes/No Kind________________________ Date________________

Do you have glaucoma?	Yes/No	Cataracts?	Yes/No	Dry eyes?	Yes/No
Macular degeneration	Yes/No	Retinal detachment	Yes/No	Blurred vision?	Yes/No
Do you wear glasses?	Yes/No	Contact lenses?	Yes/No	Type ________________	

Insurance Information

Name of insured ________________________________ Relationship to patient________________

Birth Date ____________________ Social Security#________________ Date employed______________

Work Phone ____________________ Name of employer____

Address ________________________ City________________ State________ Zip____________

Doctor Use Only

Reviewed by________________________ ☐ No changes Date ______________

CONFIDENTIAL

<u>FINANCIAL POLICY</u>

Welcome to our office. We are committed to providing you with the best possible eye care for you and your family.

All new patients are asked to complete a patient information form prior to your examination. We also request a copy of your Driver's license(s) for identification and check cashing purposes. All patients are expected to **pay in full** at the time of service. WE ACCEPT VISA, AMERICAN EXPRESS, MASTERCARD, DISCOVER, CARE CREDIT, PERSONAL CHECKS AND CASH.

Insurance patients must present your card to the front desk staff prior to your examination. Authorization of your coverage takes time and must be done prior to your exam or you will be responsible for payment. All co-payments and deductible are to be paid at the time of service. In the event that your insurance does not pay in full or denies your claim you are responsible for full payment within thirty (30) days. Your insurance plan is between you and your company. All VSP, VCP, and Davis Vision participants are responsible to understand what your plan covers. You are responsible for all overages and deductible.

Our office uses Electronic Check Services. All personal checks must have a valid Florida Driver's License and two telephone numbers. A $35.00 return check fee is charged on all returned checks. If a collection agency is necessary you are responsible for all charges plus 18% interest.

We try to give you the best possible price on all your Eyecare needs. Our coupons are as stated. We cannot change, separate, or add anything to a coupon. Coupons must be presented **before** the examination. All insurance cards must be presented **before** the examination. We thank you in advance for understanding and accepting our policy. Your satisfaction is very important to us. All sales are final. No refunds are given on discounts or coupon products. Anything left over ninety (90) days will become Val-U-Vision property.

Worker's compensation patients are responsible for proper authorization and paper work. If your claim is denied you are responsible for full payment.

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such eyecare to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ____

SIGNATURE OF PATIENT (Or parent if a minor) DATE