

PATIENT HISTORY QUESTIONNAIRE

PATIENT DEMOGRAPHICS

Date: _____ Referred by: _____

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: (____) _____ Home Phone: (____) _____ Work Phone: (____) _____

DOB: _____ Sex (Please circle): M / F Social Security #: _____ - _____ - _____

E-mail Address: _____ Education / Degree: _____

EMERGENCY CONTACT INFO

Last Name: _____ First Name: _____ Phone: (____) _____

INSURANCE INFORMATION

Employer: _____ Occupation: _____

Vision Insurance Name: _____ ID #: _____

Name of Primary Subscriber: _____ Subscriber DOB: _____

Primary Health Insurance Name: _____ ID #: _____

Secondary Health Insurance Name: _____ ID #: _____

Tertiary Health Insurance Name: _____ ID #: _____

Name of Primary Subscriber: _____ Subscriber DOB: _____

PERSONAL EYE INFORMATION

Do you use contact lenses for: _____ Distance _____ Reading _____ Both _____ Not at all

Do you use glasses for: _____ Distance _____ Reading _____ Both _____ Not at all

Do you experience: _____ Blurred Distance Vision with Glasses _____ Headache / Fatigue After Work
_____ Blurred Reading Vision with Glasses _____ Glare / Light Sensitivity

Type of contact lenses: _____ Last worn: _____

Have you ever been diagnosed with any of the following:

_____ Glaucoma	_____ Crossed Eye	_____ Dry Eye
_____ Diabetic Eye Disease	_____ Retinal Detachment	_____ Thyroid Eye Disease
_____ Macular Degeneration	_____ Bleeding in the Eye	_____ Lazy Eye
_____ Cataracts	_____ Blocked Tear Duct	_____ Eye Pain
_____ Double Vision	_____ Loss of Peripheral Vision	_____ Chronic Eye Infection

Have you had previous refractive surgery? _____ YES _____ NO Type of surgery: _____

Have you had previous ocular surgery? _____ YES _____ NO Type of surgery: _____

Have you had an eye injury? _____ YES _____ NO Date of Injury: _____

Details of injury: _____

MEDICAL INFORMATION

Primary Care Physician: _____ Phone: (____) _____

(CONTINUED ON NEXT PAGE)

Have you ever been diagnosed with any of the following:

Healthy with no medical diagnosis

- Diabetes
- Thyroid Disease
- Heart Disease
- Asthma
- Chest Pain
- Coughing up Blood
- Bloody Urine / Stool
- Swollen glands
- High Blood Pressure
- Stroke
- Arthritis
- Psychiatric Disorder
- Shortness of Breath
- Bleeding Problems
- Ringing in Ears
- Unusual Weight Loss

- Tuberculosis
- Kidney Disease
- Cancer
- Immune Problems
- Regular Coughing
- Night Sweats
- Loss of Balance / Dizziness
- Frequent Headaches

Other health issues not listed: _____

Please list all drug allergies: _____ *No Known Drug Allergies*

Please list your current medications: _____ *No Current Medications*

Please list any past surgeries: _____

How often do you drink alcohol? Never Occasional Heavy

How often do you smoke? Never Occasional Heavy

How often do you use illegal drugs? Never Occasional Heavy

FAMILY HISTORY

Has anyone in your immediate family been diagnosed with the following:

- Glaucoma
- Heart Disease
- Stroke
- Macular Degeneration
- Diabetes
- Cancer
- Heart Attack
- Retinitis Pigmentosa
- Cataracts
- Lazy Eye
- Retinal Detachment
- High Blood Pressure

HIPAA PRIVACY RULE

The HIPAA (Health Insurance Portability and Accountability ACT) notification describes in detail how your medical information may be used and disclosed. It also describes how you can access the information. I have been offered a copy of North County Laser Eye Associates HIPAA Notice of Privacy Practices. **Patient Initials:** _____

REFRACTION POLICY

Insurance companies will only pay for services that it determines to be "Medically Reasonable and Necessary." Refractions (examinations used to determine the prescription of your contacts and glasses) are most often deemed to be non-medical, and therefore are not covered by your health insurance. The cost of the exam is \$45, and I understand that I will be held personally responsible for the payment. **Patient Initials:** _____

INFORMATION REGARDING DILATING DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow a better view of the inside of your eye. These drops blur vision for a length of time and cause light sensitivity. I understand that my vision will be altered and I should use caution while driving or otherwise arrange for transportation. I hereby authorize North County Laser Eye Associates to administer dilating drops. **Patient Initials:** _____

PATIENT BALANCE RESPONSIBILITY

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account and for any professional or diagnostic services rendered as well as any glasses or contacts ordered. I authorize payment of medical benefits payable to the physician. A copy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or changes in any of the information provided on the patient information sheet. I understand that there will be a \$25 late fee for any unpaid balance on my account after 60 days. I understand that my account will be sent to collections after 90 days. I also authorize this office to release my spectacle or contact lens prescription at my request.

Patient Signature

Date