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**Patient History Questionnaire**

**Date:**

**Last: First: Initial: Nickname: Home#:**

**Address: Date of Birth: Work#:**

 **Birth Sex: SSN: Cell:**

**City: State: Zip: Email:**

**Occupation: Computer Usage:**

**Special Needs: Hobbies/Sports:**

**Parent/Guardian: Family Doctor: Dr Phone #:**

**Last Eye Exam: Alt. Contact: Alt Primary #:**

**Last Medical Exam: Relationship: Alternate# :**

 **NOTE:** For dates where exact date is unknown. Please use a number that is as close as you can remember.

**Review of Systems:**

 Do you currently or have you ever had any problems in the following areas.

**CONSTITUTIONAL**

 Fever Yes No ?

 Weight Gain/Loss Yes No ?

**INTEGUMENTARY**

 Skin Yes No ?

**NEUROLOGICAL**

 Headaches Yes No ?

 Migraines Yes No ?

 Seizures Yes No ?

**EYES**

 Loss of Vision Yes No ?

 Blurred Vision Yes No ?

 Distorted Vision/Halos Yes No ?

 Loss of Side Vision Yes No ?

 Double Vision Yes No ?

 Dryness Yes No ?

 Mucous Discharge Yes No ?

 Redness Yes No ?

 Itching Yes No ?

 Burning Yes No ?

 Foreign Body Sensation Yes No ?

 Excess Tearing Yes No ?

 Glare/Light Sensitivity Yes No ?

 Eye Pain or Soreness Yes No ?

 Chronic Infection of Eye or Lid Yes No ?

 Styes or Chalazion Yes No ?

 Flashers Yes No ?

 Floaters Yes No ?

 Tired Eyes Yes No ?

 Color Blind Yes No ?

**RESPIRATORY**

 Asthma Yes No ?

 Chronic Bronchitis Yes No ?

 Emphysema Yes No ?

 Sleep Apnea Yes No ?

**EARS, NOSE, AND THROAT**

 Allergies/Hay Fever Yes No ?

 Sinus Congestion Yes No ?

 Runny Nose Yes No ?

 Post Nasal Drip Yes No ?

 Chronic Cough Yes No ?

 Dry Throat/Mouth Yes No ?

 Ringing In Ears Yes No ?

 Ear Pain or Infection Yes No ?

 Hearing Aids Yes No ?

 Deaf Yes No ?

**VASCULAR, CARDIOVASCULAR**

 Diabetes Yes No ?

 Heart Disease Yes No ?

 High Blood Pressure Yes No ?

 High Cholesterol Yes No ?

**GASTROINTESTINAL**

 Diarrhea Yes No ?

 Constipation Yes No ?

**GENITOURINARY**

 Gonads/Kidneys/Bladder Yes No ?

**BONES, JOINTS, MUSCLES**

 Rheumatoid Arthritis Yes No ?

 Muscle Pain Yes No ?

 Joint Pain Yes No ?

**LYMPHATIC, HEMATOLOGICAL**

 Anemia Yes No ?

 Bleeding Problems Yes No ?

**ENDOCRINE**

 Thyroid/ Other Glands Yes No ?

**ALLERGIC, IMMUNOLOGIC** Yes No ?

**PSYCHIATRIC**  Yes No ?

If you answered “?” to any of the above or have a condition not listed please explain.

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**Medical History**

Do you have any allergies to medications? Yes No

 If Yes, please list,

List any medications you take (including oral contraceptives, aspirin, over the counter medications, and home remedies):

List all major injuries, surgeries, and/or hospitalizations you have had:

List any of the following that you have had:

 Prominent Eyes Yes No Crossed Eyes Yes No Lazy Eye Yes No

 Eye Infection Yes No Retinal Disease Yes No Glaucoma Yes No

 Cataracts Yes No Eye Injury Yes No Drooping Eyes Yes No

Are you Pregnant? Yes No

Do you wear glasses? Yes No If yes, how old is your present pair of glasses? Years

Do you wear contacts? Yes No If yes, how old is your present pair of lenses? Weeks

 Type of Contact Lenses: Rigid Soft Extended Wear Other Are they Comfortable Yes No

**Family History**

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

 DISEASE/CONDITION RELATIONSHIP

 Blindness Yes No ?

 Cataract Yes No ?

 Glaucoma Yes No ?

 Crossed Eyes Yes No ?

 Macular Degeneration Yes No ?

 Retinal Detachment/Disease Yes No ?

 Arthritis Yes No ?

 Cancer Yes No ?

 Diabetes Yes No ?

 Heart Disease Yes No ?

 High Blood Pressure Yes No ?

 High Cholesterol Yes No ?

 Kidney Disease Yes No ?

 Lupus Yes No ?

 Other Yes No ?

 If Other, Explain

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**Social History**

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

 I WOULD PREFER TO DISCUSS MY SOCIAL HISTORY INFORMATION DIRECTLY WITH MY DOCTOR.

 Do You Drive? Yes No If yes, do you have any visual difficulty when driving? Yes No

 If yes, please describe

Do you use:

 Tobacco Products Yes No If yes, type / amount / how long?

 Alcohol Yes No If yes, type / amount / how long?

 Recreational Drugs Yes No If yes, type / amount / how long?

Have you ever been exposed to or infected with:

 Gonorrhea Yes No ? Hepatitis Yes No ?

 Syphilis Yes No ? HIV/AIDS Yes No ?

**Patient / Insurance Information**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: White Black Asian American Indian Pacific Islander

Ethnicity: Hispanic Non-Hispanic

**Primary Policyholder’s Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship To Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How Did You Hear About Us**

Drive By/Saw sign:

Internet Search: if so, which site?

Family/Friend Referral: if so, who?

Yellow Pages/Phone Book:

Other:

**Consent for Treatment, Payment, Coordination of Care Practices,**

**And Assignment of Benefits to Physician**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please **INITIAL** next to the following:

\_\_\_\_\_I understand that as part of my health care, Northside Vision maintains paper and electronic records describing my personal and family health history, test results, demographic information, insurance information, and any plans for the future care of treatment.

\_\_\_\_\_I request that payment of authorized Medicare and / or other insurance benefits be made on my behalf to my provider for services rendered to me.

\_\_\_\_\_I authorize the release of any medical or other information necessary to process claims related to services rendered by the physicians at Northside Vision.

\_\_\_\_\_I authorize the release of any medical records from any healthcare provider to this physician for the purpose of providing coordinated healthcare services, and I authorize the release of any medical records from this physician to any healthcare provider for the coordination of my medical care.

\_\_\_\_\_I authorize Northside Vision to obtain my medication history from secure internet sources.

\_\_\_\_\_I agree that I am solely responsible for all charges related to my visit. I understand that I am responsible for any and all balances due after insurance payments have been applied. I also understand that the statement will be mailed with any balance unpaid by insurance and that this balance is due within 30 days of the postmarked date. I understand that all copays/ deductibles are due when services are rendered and that there is a $25 return check fee.

**PLEASE TURN PAGE OVER**

**DISCLOSURE OF MEDICAL INFORMATION**

**Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Disclosure of medical information: Your medical information and communication of that information is essential to your care. We prefer to speak directly with each patient but we understand that other individuals and family members may have knowledge of and be assisting in your care. Please list the individuals with whom we are authorized to discuss your care. (**NOTE**: We cannot discuss your care with others, including your spouse or other family living with you unless they are listed below.)

**Name of Person Relationship to Patient**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Confidential Communication:** Communication between this practice and you, the patient, is critical to your health. We may leave messages or sent text and or emails to confirm your appointment or to notify you that your glasses or contacts are ready to be picked up. A request for calls may be left on the following answering machines, voice mail, text and email. Check all that apply:

HOME WORK CELL EMAIL

I hereby authorize the use and disclosure of personal health information as described above:

Patient or Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed, I understand that I should read it carefully. I am aware that the Notice may be changed at anytime. I may obtain a copy of revisions of the Notice by calling 864-578-3926 or requesting one at Northside Vision office.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As a representative of the above individual, I acknowledge receipt of the notice on his or her behalf.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

**About Your Insurance**

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both: Vision care plans such as (VSP & EyeMed) and Medical insurance such as (BlueCross/BlueShield and Medicare). Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye disease.

Medical insurance must be used if you have any eye health problems or systemic health problems that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history such as **diabetes, glaucoma or cataracts**.

If you have both types of insurance plans it may be necessary for us to bill some to your medical and some to your vision plan. We can only use coordination of benefits when your insurance allows us to. This is to minimize your out-of-pocket expenses. You will be responsible for any deductibles or copays that your insurance may have at the time of service.

Please provide all your insurance cards to our front desk staff members.

I have read and agree with these policies.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (parent of child) Date

**24 Hour Cancellation/Missed Appointment Fee Policy**

Each time a patient misses an appointment without providing proper notice another patient is prevented from receiving care. Therefore, Northside Vision reserves the right to charge a fee of $35.00 for all missed appointments and appointments which, absent a compelling reason, are not cancelled with a 24-hour notice.

This fee will be billed to the patient, is not covered by insurance, and must be paid prior to your next appointment. Multiple missed appointments in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

**By signing below, you acknowledge that you have received this notice and understand this policy.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Patient Name Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Patient/Guardian Signature**