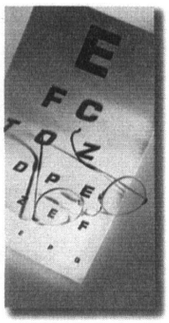

PATIENT HISTORY QUESTIONNAIRE

Date _____

Last name _____First name_____MI_____

Address _____City_____State_____Zip_____

Cell phone ( ) _____Home phone ( )_____SSN_____-_____-_____

DOB _____Occupation_____Employer_____

Emergency contact name _____Phone number ( )_____ Pregnant or Nursing? Yes / No

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 **Male** or **Female**

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
Elevated cholesterol	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 _____	
Floaters or flashes?	Yes/No	Pain or irritation?	Yes/No		

Insurance Information

Name of Insurance _____ Member ID# _____

Name of insured _____Relationship to patient_____

Birth Date _____Social Security#_____Date employed_____

Work Phone _____Name of employer_____

Employer Address _____City_____State_____Zip_____

CONFIDENTIAL

FINANCIAL POLICY

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