INDEPENDENT EYE Care

Last Name: _____

First Name: _____ MI_____

Birth Date:_____

Address: _____

City/State/Zip:_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email:_____

Occupation:_____

Referred By: _____

HIPAA PRIVACY

Acknowledgement of Receipt of Privacy Notice

By signing this acknowledgement of Receipt of Privacy Practices (the "Notice"); I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below.

I understand that the location may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit the location to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims and communicate with me regarding vision care services provided by the location (For example, mailings of exam reminders or information about services/products by the location).

I can be assured that this location does not sell my person health information of any kind to a third party for such party's own use. I authorize the Location to submit my vision benefit claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received from this Location.

_____ _____

Patient Signature or Patient's Legal Representative Date

MEDICAL HISTORY QUESTIONNAIRE

Primary reason for today's visit: _____

Is it your first? _____

Do you presently have any problems in the following areas? (Check all that apply)

❑ Eyes	❑ Loss or blurred vision	❑ Loss of side vision, double vision
❑ Itching, burning or discharge	❑ Redness	❑ Gritty feeling, dryness or tearing
❑ Glare/light sensitivity or halos	❑ Eye pain or soreness	❑ Infection of eye lashes or lids, sty's
❑ Ears, nose, mouth, throat	❑ Cardiovascular (heart, blood vessels)	❑ Respiratory (lungs/breathing)
❑ Gastrointestinal (stomach/intestines)	❑ Genitourinary (genitals/kidney/bladder)	❑ Musculoskeletal (muscles/joints)
❑ Integument (skin/breast)	❑ Neurological	❑ Psychiatric
❑ Endocrine (hormones, glands)	❑ Hematologic/Immunologic (blood)	❑ Seasonal Allergies (hay fever, etc)

Notes:_____

PAST VISION HISTORY:

❑ History of cataract glaucoma ❑ History of cross/lazy eye ❑ Eye injury or other disease

❑ Eye drops currently in use ❑ Allergies to eye drops? List:

❑ Eye surgery ❑ Other:_____

PAST MEDICAL HISTORY:

List any medications (other than eye drops) that you are currently using: _____

_____

List all major illnesses:

❑ Diabetes ❑ Hypertension ❑ Cancer

❑ Other: _____

List any major surgical procedures: _____

Allergies to medication?

❑ Penicillin ❑ Sulfa ❑ Other _____

FAMILY HISTORY:

OCULAR

❑ Blindness ❑ Cataract ❑ Glaucoma

❑ Macular Degeneration ❑ Retinal Detachment ❑ Other _____

MEDICAL

❑ Diabetes ❑ Arthritis ❑ Lupus

❑ Other _____

SOCIAL HISTORY:

OCULAR

❑ Contact Lenses ❑ Problems wearing contacts ❑ Other:_____

Vision problems have caused issues with the following:

❑ Driving ❑ Night vision ❑ Reading

❑ Sports/Outdoor activities ❑ Other:_____

GENERAL	Daily	Weekly	Monthly
Do you drink alcohol?	❑	❑	❑
Do you smoke?	❑ _____per day	❑	❑

Have you ever had a blood transfusion? _____

Have you ever had contact with a person who had a sexually transmitted disease? _____

Patient's Signature _____ Date _____

Physician's Signature _____ Date _____

History Reviewed: ❑ No changes ❑ Additions as noted