

PATIENT HISTORY QUESTIONNAIRE

Thank you for choosing our office. In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date _____

Dr. Miss Last Name _____ First Name _____ MI _____

Mr. Ms. Address _____ City _____ State ____ Zip _____

Mrs. Other ____ Home phone _____ Work phone _____ Cell phone _____

How would you like us to contact you? _____ SS# _____ Birthdate _____ Gender M/F ____

Patient or parent/guardian's employer _____ Patient occupation _____

Emergency contact _____ Phone _____ Relationship to patient _____

Spouse or parent/guardian name _____ Employer _____ Phone _____

Patient: Full-Time Student? Yes No

Whom may we thank for referring you? _____

How did you find out about our office? _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____ Cell phone _____

Drivers license # _____ Birthdate _____ Employer _____ Work phone _____

Is this person a patient in our office? ____ Have we seen any other members of your family? ____ If so, whom _____

INSURANCE INFORMATION

Routine Well Vision Insurance:

Name of insured _____

Relation to patient _____ Birthdate _____

Insured SS/ID# _____ Group# _____

Insurance _____

Employer _____

Medical Insurance:

Name of insured _____

Relation to patient _____ Birthdate _____

Insured SS/ID# _____ Group # _____

Insurance _____

Employer _____

Authorization & Release

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to the doctor. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I agree to be financially responsible for all charges relative to my provider plan.

If *Crystal Vision Center* is not a provider for my insurance, I understand that they will assist me in receiving reimbursement as much as possible but I am responsible for my bill at the time of services.

I have read and understand this information.

X _____ Date _____

Signature of patient (or parent/guardian if minor)

MEDICAL INFORMATION

Date _____

Date of last eye exam _____ Dilated? _____ Eye doctor name _____

Eye doctor location _____

Describe your general health: _____

Do you have problems with any of these systems? (Please circle Y or N)

Gastrointestinal Y/N Nervous Y/N Allergy/immunologic Y/N

Ears/Nose/Throat Y/N Genitourinary Y/N Mental Y/N

Cardiovascular Y/N Musculoskeletal Y/N Endocrine (glands) Y/N

Respiratory Y/N Integumentary (skin) Y/N Blood/Lymph Y/N

Please explain: _____

Please answer all questions below:

Diabetes Y/N Type _____ Date of Diagnosis _____

Headaches Y/N Describe _____

Medication allergies Y/N List and describe reaction _____

Other Allergies Y/N List and describe reaction _____

Other health problems _____

Current Medication(s) _____

Have you had any operations? Y/N Type? _____

Do you use cigarettes/tobacco? _____ Alcohol? _____ Other Substance(s)? _____

Name of family doctor _____ Date of last visit _____

Date of last tetanus shot _____ Do you have an advance directive for health care? Y/N

FAMILY HISTORY

Glaucoma Y/N Relation _____ Retinal detachment Y/N Relation _____

Cataracts Y/N Relation _____ High blood pressure Y/N Relation _____

Macular degeneration Y/N Relation _____ Diabetes Y/N Relation _____

Other eye conditions Y/N Relation _____ Type _____

PERSONAL EYE INFORMATION

Have you had any eye operations? Y/N Type _____ Date _____

Have you had an eye injury? Y/N Type _____ Date _____

Do you have glaucoma? Y/N Cataracts? Y/N Dry Eyes? Y/N Blurred vision? Y/N

Other eye problems? Y/N

What kind? _____

Do you wear glasses? Y/N

Contact Lenses? Y/N Type _____

Additional information _____