Medical History Questionnaire

Name: _____ Today's Date: ____/____/____

DOB: __/__/__

Medical History

Do you have any allergies to medications? ☐ no ☐ yes If yes, explain: _____

_____

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: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal diease, cataracts, eye infections or eye injury: _____

Are you pregant and/or nursing? ☐ no ☐ yes

Family History

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

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other _____	☐	☐	☐	_____

Social History

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

☐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check Box)

Do you drive? ☐ no ☐ yes If yes, do you have visual difficulty driving? ☐ no ☐ yes If yes, please describe:

_____

Do you use tobacco products? ☐ no ☐ yes If yes, type/amount/how long: _____

Do you drink alcohol? ☐ no ☐ yes If yes, type/amount/how long: _____

Do you use Illegal Drugs? ☐ no ☐ yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Please turn this form over and complete side two

Review of Systems

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

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
INTEGUMENTRAY (skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Grtty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foriegn Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR/ CARDIOVASCULAR			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrha	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC/HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
ALLERGIC/IMMUNOLOGIC	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

If you answered YES to any of the above or have a conditions not listed, please explain & list medications:

_____

_____

_____

_____

_____

_____ _____

Doctor's Signature Date

(For Office Use Only) I have reviewed and updated the above information. (Please initial & date)

Initial_____Date_____ Initial_____Date_____ Initial_____Date_____

Initial_____Date_____ Initial_____Date_____ Initial_____Date_____

Initial_____Date_____ Initial_____Date_____ Initial_____Date_____

Initial_____Date_____ Initial_____Date_____ Initial_____Date_____

Initial_____Date_____ Initial_____Date_____ Initial_____Date_____

Patient Registration

Patient Information

Name: _____

Circle one: Dr Mr Mrs Ms Miss Jr Sr I II III

Address:

_____

City: _____ State: _____ Zip: _____

Home phone: ( ) _____-_____
Work phone : ( ) _____-_____
Cell phone: ( ) _____-_____

Circle one of the following that applies to the patient:
I am employed: Full time Part time

Self employed Homemaker Retired

Currently unemployed

Employer:

_____

Occupation:

_____

Date of Birth: ____/____/_____ Sex: M or F

Social Security number: _____/____/_____

Circle one: I am: Married Single Widowed Domestic Partner

If student, circle one: Full time Part time

Medical Doctor: _____
MD Phone #: _____

Your email is only used for our office's professional purposes and will never be shared with any outside persons or sources.

Email:

_____

For New Patients:

Whom may we thank for referring you?

_____

Spouse or Parent Information

Name: _____
DOB: ___/___/_____
Relationship to patient: _____

Employer: _____
Address: _____

Work phone: ( ) _____-____-____

ADVANCED EYE GROUP, LLC.

206 N. MAIN RD * VINELAND, NJ 08360 * 856-691-0720

STATEMENT OF RESPONSIBILITY/FINANCIAL ASSIGNMENT & RELEASE

Please initial each statement and sign/print

IF YOU HAVE HEALTH INSURANCE OF ANY KIND, PLEASE READ OUR POLICY:

We will do everything we can to help you obtain reimbursement from your insurance carrier; however, the basic responsibility is yours. As a courtesy to you, we will send claims to your insurance company. However, we cannot accept the responsibility for negotiating claims with insurance companies or other parties.

Please check with your insurance company to see if a ***referral*** is required for your visit. If one is needed, it is your responsibility to obtain one ***prior*** to your visit. If no referral is issued, we will have to reschedule your appointment. I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered. _____

Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claims. You agree to be financially responsible to reimburse all fees for services not collected in full at the date of service should your insurance or vision plan denial in part or in the entire claim. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. _____

I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive, and I agree to make payment in full. _____

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full. _____

If you do not inform us you have a vision plan or medical insurance before services are rendered, we will assume no coverage exists. _____

I agree I am responsible to file my own claim if I discover I have vision or medical benefits after services or products are rendered. _____

I agree this office, with NO EXCEPTIONS will not back date and file claims, post authorize claims, or refund fees after services are rendered due to lack of notification of vision or medical benefits. _____

_____ _____

Patient Signature Date

_____

Print

ADVANCED EYE GROUP, LLC.

206 N. MAIN RD * VINELAND, NJ 08360 * 856-691-0720

REFRACTION FEE

The refraction is the portion of your comprehensive eye exam in which your eyeglass or contact lens prescription is determined. If your insurance does not provide routine eye exams this fee of $29 is due at the time services are rendered.

I have been notified that my refraction done today will not/may not be covered by my insurance and I assume responsibility for this fee.

_____ _____

Patient Signature Date

I have read the above and do not want the refraction portion of my eye exam done today.

_____ _____

Patient Signature Date

HIPAA Privacy Acknowledgement of Notice of Privacy Practices

I, _____ have been presented with the Notice of Privacy Policy of Advanced Eye Group and have been offered a copy of such policy to keep for my records.

I decline receipt of the written policy _____ _____

Patient Signature Date

I accepted a copy of the written policy _____ _____

Patient Signature Date

WITH WHOM DO WE HAVE PERMISSION TO DISCUSS YOUR MEDICAL INFORMATION WITH?

NAME _____ **RELATIONSHIP** _____ **DATE** _____

NAME _____ **RELATIONSHIP** _____ **DATE** _____

NAME _____ **RELATIONSHIP** _____ **DATE** _____