PATIENT INFORMATION QUESTIONNAIRE

DEAR PATIENT:

So that we may better meet your vision care needs, please complete the questions below regarding your visit to our office and your participation in hobbies, sports, and computer usage.

1. Your reason(s) for visiting our office today: (Please check appropriate items)

__General check-up	__Blurred distance vision	__Eyes water
__Lost or broken eyeglasses	__Blurred near vision	__Eyes itch
__Want new eyeglasses	__Eyes feel tired	__Eyes feel dry
__Want contact lenses	__Double vision	__Pain in eyes
__Soft disposable	__Headaches	__Night vision
__Light sensitive	__Golf glasses	__Interested in Lasik
__Bifocal contact lenses	__Other (please list):	
__Gas permeable	_____	

2. Please circle those activities in which you participate.

Golfing	Basketball	Skiing	Football	Baseball/Softball
Tennis/Racquetball	Soccer	Hunting	Fishing	Swimming
Bowling	Volleyball	Biking	TV	Walking/Jogging
Rollerblading	Dancing	Aerobics	Reading	Gardening
Crafting	Musical	Scuba	Sewing	Woodworking
Instrument	Boating			

3. How many times a day do you use the computer? _____

THANK YOU !

PATIENT INFORMATION

DATE _____

LAST NAME_____ **FIRST NAME** _____

ADDRESS _____

CITY _____ **STATE**_____ **ZIP**_____

HOME PHONE _____ **WORK PHONE**_____

CELL PHONE _____ **E-MAIL** _____

BIRTHDAY____/____/____ **SOCIAL SECURITY #** _____

MARITAL STATUS S M D W

SPOUSE'S NAME _____

PERSON RESPONSIBLE FOR BILL _____

ADDRESS_____ **CITY** _____ **ZIP** _____

BIRTHDAY ____/____/____ **PHONE NUMBER** _____

YOUR SIGNATURE ON THIS FORM WILL SERVE AS OUR "SIGNATURE ON FILE" FOR INSURANCE FORMS_____

*****IF YOU HAVE INSURANCE OUR OFFICE WILL BILL AND ACCEPT PAYMENT DIRECTLY FROM THEM IF THE SERVICES QUALIFY FOR COVERAGE. ANY CHARGES NOT COVERED ARE PAYABLE BY THE PATIENT. YOUR SIGNATURE HERE WILL SERVE AS YOUR AGREEMENT TO PAY FOR SERVICES AND MATERIALS NOT COVERED. *****

SIGNATURE_____ DATE_____

WERE YOU REFERED TO OUR OFFICE? IF SO, BY WHOM?

_____

PATIENT HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____

Primary Care Physician: _____

Were you referred? ☐ Yes ☐ No If so, by whom? _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: (including eye drops, vitamins, supplements etc…) _____

_____

Allergies to medication or food: _____

OCULAR HISTORY: (please check yes or no and explain all that apply)

	Yes	No	
Blurred, Distorted or Double Vision	☐	☐	_____
Loss of Vision or Fluctuation of Vision	☐	☐	_____
Mucous Discharge	☐	☐	_____
Floaters/ Flashes	☐	☐	_____
Pain/ Soreness	☐	☐	_____
Chronic infection	☐	☐	_____
Eye Surgery	☐	☐	_____
Other	☐	☐	_____

Review of Systems: (please check yes or no and explain all that apply)

Constitutional Systems:	**Yes**	**No**	
Fever, weight loss, other	☐	☐	_____
Ears, Nose, Mouth, Throat:			
Hearing or sinus problems	☐	☐	_____
Cardiovascular System:			
High blood pressure	☐	☐	_____
High Cholesterol	☐	☐	_____
Heart disease/heart attack	☐	☐	_____
Heart surgery/Other	☐	☐	_____
Respiratory Systems: (lungs, breathing)			
Asthma, emphysema, TB	☐	☐	_____
Shortness of breath	☐	☐	_____
Gastrointestinal: (stomach, intestine)			
Jaundice, hepatitis, ulcers	☐	☐	_____
Hernia, reflux, GI bleeding	☐	☐	_____
Genitourinary: (genital, kidney, bladder)			
Kidney disease, pain	☐	☐	_____
Frequent urination	☐	☐	_____
Integumentary: (skin and/or breast)			
Skin disease, skin cancer	☐	☐	_____
Musculo-skeletal			

Degenerative arthritis	☐	☐	
Rheumatoid arthritis	☐	☐	
Lupus/ Other	☐	☐	
Neurological			
Fainting, dizziness	☐	☐	
Migraines, seizures	☐	☐	
Stroke, paralysis	☐	☐	
Psychiatric			
Depression	☐	☐	
Schizophrenia/ Other	☐	☐	
Hematologic / Lymphatic			
Anemia, sickle cell	☐	☐	
Bleeding disorder	☐	☐	
Leukemia/ Other	☐	☐	
Allergic/ Immunologic			
Seasonal allergies	☐	☐	
Immune disorder	☐	☐	
Hay fever/ other	☐	☐	
Endocrine			
Diabetes, Type 1	☐	☐	
Diabetes, Type 2	☐	☐	
Thyroid	☐	☐	
Hormone replacement	☐	☐	
HIV/ AIDS:	☐	☐	

List past surgeries:

Date:	**Type:**	**Date:**	**Type:**

Describe any other problems, illnesses, or conditions that were not previously mentioned:

FAMILY HISTORY: Do you have a family history of:

	Yes	**No**	**Family member:**
Diabetes	☐	☐	
Glaucoma	☐	☐	
Macular degeneration	☐	☐	
Retinal detachment	☐	☐	
Other eye disease	☐	☐	
Social History:	**Yes**	**No**	**Please explain:**
Do you drink alcohol?	☐	☐	
Do you smoke?	☐	☐	

Initial

Date

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and optical products. You may have both types and Dr. Waguespack's office accepts most insurance plans in both categories: (1) **vision plans** (such as VSP and Always) and (2) **medical insurance** (such as Blue Cross/Blue Shield, Medicare and others).

- Vision plans only cover routine vision wellness exams, along with eyeglasses, and contact lenses. Vision plans do not cover medical eye care (the diagnosis, management or treatment of eye health problems).
- Medical insurance must be used for medical eye care.
- If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called "Coordination of Benefits" to do this properly and to minimize your out-of-pocket expense.
- If some fees are not paid by your insurance, we will bill you for them, such as deductibles, co-pays, or non-covered services as allowed by the insurance contract.

Please provide your insurance cards to our staff member so we can make a copy. We need to have your medical insurance card or Medicare on file in case we should need it in the future for billing your insurance.

I have read and accept these policies.

_____ _____

Patient Signature (Parent if Child) **Date**