BASS LAKE FAMILY EYE CARE

12750 Bass Lake Rd. Maple Grove, MN 55369
Phone: 763-553-1811
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# Health History Form 11/12

www.basslakefamilyeyecare.com

**Personal Information:**

Name: _____ ☐ Married ☐ Single Date: _____

Preferred Name: _____ Gender: ☐ Male ☐ Female Date of Birth: _____

Address: _____
City State Zip Code

Phone: Home_____ Work_____ Cell_____

Email Address: _____ (We will only use your email for office communication/appointment information)

Employer: _____ Occupation: _____

Person Responsible for Account: _____ Whom may we thank for referring you?_____

Do you have any special needs? (for example: hearing-impaired, wheelchair access, etc…) _____

Do you drive? ☐ Yes ☐ No Primary Language: _____

**Insurance Information:**

Insurance Company: _____ SSN (last 4)XXX-XX-_____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Relationship to Patient: _____ Employer of Policy Holder: _____

**Please Read & Sign:**

☐ I understand the insurance information I give is the information used to file my insurance claim and this is private information between the policy holder, the insurance company, and the employer. Therefore, I am responsible for checking my eligibility.

☐ I understand that although Bass Lake Family Eye Care is a provider for most insurance companies, non payment can occur and it is then my responsibility to provide payment for services rendered.

☐ I authorize payment of my medical/vision insurance benefits to Bass Lake Family Eye Care for services rendered and products purchased.

**Signature:** _____ **Date:** _____

**HIPAA/Notice of Privacy Policy Acknowledgment:**

This is a summary of how health information about you may be used. A full notice of your privacy rights will be provided upon request.

Bass Lake Family Eye Care uses health information about you for treatment, in obtaining payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

Bass Lake Family Eye Care will not disclose your information to others unless given permission or the law authorizes/requires us to do so.

Bass Lake Family Eye Care must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed and permitted by law.

**Signature:** _____ **Date:** _____

**Patient Health / Ocular History and Information:**

BASS LAKE FAMILY EYE CARE

Primary Care Clinic Name & Location: _____

Primary Doctor's Name: _____ Date of last physical exam: _____

Date & Location of Last Eye Exam: _____

Please list all prescribed and over the counter medications you are taking: _____

_____

Please list all allergies you have (medication or environmental):_____

**Do you currently wear:** Glasses ☐ Yes ☐ No Contact Lenses ☐ Yes ☐ No

**Have you or any family members been diagnosed with the following (if so please list relationship)?**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Glaucoma | ☐ Yes | ☐ No | _____ | Autoimmune Disease | ☐ Yes | ☐ No | _____ |
| Cataract | ☐ Yes | ☐ No | _____ | Cancer | ☐ Yes | ☐ No | _____ |
| Macular Degeneration | ☐ Yes | ☐ No | _____ | Diabetes | ☐ Yes | ☐ No | _____ |
| Retinal Detachment | ☐ Yes | ☐ No | _____ | Heart Disease | ☐ Yes | ☐ No | _____ |
| Color Blindness | ☐ Yes | ☐ No | _____ | High Blood Pressure | ☐ Yes | ☐ No | _____ |
| Amblyopia (lazy eye) | ☐ Yes | ☐ No | _____ | High Cholesterol | ☐ Yes | ☐ No | _____ |
| Eye Injury/Surgery | ☐ Yes | ☐ No | _____ | Kidney Disease | ☐ Yes | ☐ No | _____ |
| Eye Infection | ☐ Yes | ☐ No | _____ | Neurological Disease | ☐ Yes | ☐ No | _____ |
| Strabismus (crossed eye) | ☐ Yes | ☐ No | _____ | Thyroid Disease | ☐ Yes | ☐ No | _____ |
| Blindness | ☐ Yes | ☐ No | _____ | Other: _____ | | | |

**Have you been experiencing any of these problems/conditions?**

☐ Recent weight loss or gain
☐ Ear, nose, throat or sinus problems
☐ Breathing problems
☐ Digestive problems
☐ Kidney/bladder problems
☐ Muscles, joint, bone problems
☐ Skin problems
☐ Mental health problems (depression/anxiety)
☐ Blood/lymph problems
☐ Chronic headaches

☐ Glare / Light Sensitivity
☐ Tired Eyes
☐ Burning / Watery / Dry Eyes
☐ Eye Pain / Irritation
☐ Itchy Eyes
☐ Mucus Discharge
☐ Droopy Lid
☐ Redness
☐ Blurred Vision
☐ Double Vision
☐ Floaters / Flashes of light
☐ Loss of Vision

Are you pregnant or nursing: ☐ Yes ☐ No

**Social History: (**this information is kept confidential, however you may discuss this portion with the doctor directly if you prefer)

Do you use any of the following:

| | | | |
|---|---|---|---|
| Alcohol? | ☐ Yes | ☐ No | Type, amount, how long: _____ |
| Tobacco? | ☐ Yes | ☐ No | Type, amount, how long: _____ |
| Recreational drugs? | ☐ Yes | ☐ No | Type, amount, how long: _____ |

Please indicate your race/ethnicity:

☐ White ☐ Black/African American ☐ Asian ☐ Other: _____
☐ American Indian ☐ Native Hawaiian/ Pacific Islander ☐ Hispanic/Latino ☐ Decline to Answer

**Signature:** _____ **Date:** _____

Initial: _____ Date: _____ Initial: _____ Date: _____ Initial: _____ Date: _____

Initial: _____ Date: _____ Initial: _____ Date: _____ Initial: _____ Date: _____