12750 Bass Lake Rd. Maple Grove, MN 55369
Phone: 763-553-1811
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www.blfec.com

Health History Form 04/22

Personal Information:

Name: ______________________________ ☐ Married ☐ Single Date: ____________________

Preferred Name: ____________________ Sex: ☐ 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: ______________________________Policy Holder's 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, **nonpayment** 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:

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	☐ Relation__________	Autoimmune Disease	☐ Relation__________
Cataract	☐ Relation__________	Cancer	☐ Relation__________
Macular Degeneration	☐ Relation__________	Diabetes	☐ Relation__________
Retinal Detachment	☐ Relation__________	Heart Disease	☐ Relation__________
Color Blindness	☐ Relation__________	High Blood Pressure	☐ Relation__________
Amblyopia (lazy eye)	☐ Relation__________	High Cholesterol	☐ Relation__________
Eye Injury/Surgery	☐ Relation__________	Kidney Disease	☐ Relation__________
Eye Infection	☐ Relation__________	Neurological Disease	☐ Relation__________
Strabismus (crossed eye)	☐ Relation__________	Thyroid Disease	☐ Relation__________
Blindness	☐ Relation__________	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: _________