PATIENT HISTORY EVALUATION SHEET

Date ________________

IMPORTANT: This Questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name ________________ First Name ________________ MI ______

Address ________________ City ________________ State ________ Zip ______

Email ________________

Cell Phone ________________ Work Phone ________________ Home Phone ________________

Date of Birth ________________ Occupation ________________ Employer ________________

Emergency Contact Name ________________ Phone Number ________________

Date of Last Eye Exam ________________ Dialated? *Yes/No*

MEDICAL INFORMATION

How is your general health? ________________

Do you take medication for any of these systems? *(please circle yes or no)*

Gastrointestinal - *Yes / No*

Ears/Nose/Throat - *Yes / No*

Cardiovascular - *Yes / No*

Respiratory - *Yes / No*

High Blood Pressure - *Yes / No*

Nervous - *Yes / No*

Urinary - *Yes / No*

Muscles/Bones - *Yes/No*

Integumentary (skin) - *Yes / No*

Eyes - *Yes / No*

Endocrine (glands) - *Yes / No*

Blood/Lymph - *Yes / No*

Allergic/Immunologic - *Yes/No*

Headaches - *Yes / No*

Mental - *Yes / No*

Please Explain ________________

Diabetes *Yes/No* ________________ Type ________________ Date of diagnosis ________________

Allergies to medication *Yes/No* Which? ________________ Reactions? ________________

Other health problems ________________

Current medication(s) ________________

Have you had any operations? *Yes/No* Kind? ________________ When? ________________

Name of family doctor and/or primary care physician ________________

Date of last visit ________________ Date your blood pressure was last checked ________________

FAMILY HISTORY

High blood pressure - *Yes/No* Relation ________________

Diabetes - *Yes/No* Relation ________________

Glaucoma - *Yes/No* Relation ________________

Macular degeneration - *Yes/No* Relation ________________

Retinal detachment - *Yes/No* Relation ________________

Cataracts - *Yes/No* Relation ________________

PERSONAL EYE INFORMATION

Do you have any eye conditions or problems? *Yes/no* What kind? ________________

Have you had any eye operations? *Yes/No* Type ________________ Date ________________

Have you had any eye injury? *Yes/No* Kind ________________ Date ________________

Do you have Glaucoma? - *Yes/No*

Macular Degeneration? - *Yes/No*

Do you wear glasses? - *Yes/No*

Cataracts? - *Yes/No*

Retinal Detachment? - *Yes/No*

Contact Lenses? - *Yes/No* *(if yes)* Type ________________

Dry Eyes? - *Yes/No*

Blurred vision? - *Yes/No*

Additional information ________________

I understand if I fail to pay for any charges owed American Vision Center, I will be responsible for all collection costs incurred.

I have completed the information above to the best of my knowledge. ________________
signature

Who may we thank for your referral? ________________

INSURANCE INFORMATION

PRIMARY INSURANCE

Primary Holder's Name________________________ Ins Co Name________________________

Policy Holder's ID #________________________ Group________________________

Birth date______________ SS#________________ Employer________________

SECONDARY INSURANCE

Primary Holder's Name________________________ Ins Co Name________________________

Policy Holder's ID #________________________ Group________________________

Birth date______________ SS#________________ Employer________________

OTHER INSURANCE

Primary Holder's Name________________________ Ins Co Name________________________

Policy Holder's ID #________________________ Group________________________

Birth date______________ SS#________________ Employer________________

FINANCIAL RESPONSIBILITY & INSURANCE RELEASE / ASSIGNMENT

I herby authorize American Vision Center to release to my insurance company any information including the diagnosis and the records of any treatment or examination, as well as any optical services, rendered to me. **For billing purposes I understand and authorize the following:**

- Direct my insurance company to issue all payments directly to American Vision Center.
- Any money received from my insurance company over and above my indebtedness will be refunded to me when my account is paid in full.
- I shall be financially responsible for charges regardless of my insurance benefits and for services not covered or paid by my insurance company.
- I shall be responsible for any additional collection charges, legal fees and attorney fees should my account need to be sent to an outside collection agency or when court action is required.

Date:______________ Signed:________________________

Date:______________ Witness:________________________

MEDICARE RELEASE AND ASSIGNMENT

I request that payment of authorized Medicare benefits be made on my behalf to American Vision Center for services furnished to me by the provider. I authorize any holder of medical information about me to release benefits or the benifits payable for related service.

Date:______________ Signed:________________________

SECONDARY INSURANCE

I request that payment of authorized insurance benefits paid by my insurance company be made to either me, or on my behalf, to American Vision Center for services furnished. This authorization is valid for all services furnished until it is revoked.

Date:______________ Signed:________________________