Exam Date: _____

Patient History Questionnaire

Last Name: _____ **First Name:** _____ **Middle Initial:** ___

Preferred Name: _____ **Sex:** _____ **SSN:** _____

Address: _____ **Date of Birth** _____

_____ **City:** _____ **State:** _____ **ZIP:** _____

Ma**rital Status**: ____Single ____Married ____Divorced ___Widowed

Home Phone: _____ **Email:**_____

Work Phone: _____ **Cell Phone:** _____

Employer: _____ **Employer Phone:** _____

Smoking Status: __Never __Former Smoker __Current Every Day Smoker __Current Some Days Smoker

Race: ____American Indian ___Asian ___ African American ___ Pacific Islander ___ White

Ethnicity (please choose one): ____ Hispanic ____ Not Hispanic

Occupation: _____ **Computer Usage:** _____hours/week

Special Visual Needs: _____ **Hobbies/Sports:**_____

Referred By: ___ Friend ___ Family ___ Internet ___ Doctor ____ Building ___ Insurance

Parent/Guardian: _____

Last Eye Exam: _____ **Alt. Contact:** _____

Last Medical Exam: _____ **Relationship**:_____

Alt. Contact Phone Number: _____

Family Doctor: _____ **Phone:** _____

Review of Systems Do you currently or have you ever had any problems in the following areas: (MARK ALL THAT APPLY)

CONSTITUTIONAL

____Fever

____Weight Gain/Loss

INTEGUMENTARY

____Skin

NEUROLOGICAL

____Headaches

____Migraines

____Seizures

EYES

____Loss of Vision

____Blurred Vision

____Distorted Vision/Halos

____Loss of Side Vision

____Double Vision

____Dryness

____Mucous Discharge

____Redness

____Itching

____Burning

____Foreign Body Sensation

____Excessive Tearing

____Glare/Light Sensitivity

____Eye Pain/Soreness

____Chronic Infection of Eye or Lid

____Styes or Chalazion

____Flashes

____Floaters in Vision

____Tired Eyes

EAR, NOSE, AND THROAT

____Allergies/Hay Fever

____Sinus Congestion

____Runny Nose

____Post-Nasal Drip

____Chronic Cough

____ Dry Throat/Mouth

____ Ringing in Ears

____ Ear Pain or Infection

____Hearing Aids

____Deafness

VASCULAR, CARDIOVASCULAR

____Diabetes

____Heart Disease

____High Blood Pressure

____High Cholesterol

GASTROINTESTINAL

____Diarrhea

____Constipation

G**ENITOURINARY**

____Gonads/Kidneys/Bladder

BONES/JOINTS/MUSCLES

____Rheumatoid Arthritis

____Muscle Pain

____Joint Pain

LYMPHATIC/HEMATOLOGICAL

____Anemia

____Bleeding Problems

ENDOCRINE

____Color Blindness ____Thyroid/Other Glands

RESPIRATORY P**SYCHIATRIC**

____Asthma ____ Depression

____Chronic Bronchitis

____Emphysema **Other Conditions not listed: _____**

____Sleep Apnea _____

Medical History

Do you have any allergies to medications? __ Yes __ No If YES, what are you allergic to? _____

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:_____

_____

Mark any of the following that you have had:

___ Prominent Eyes ___ Crossed Eyes ___ Lazy eye

___ Eye Infection ___ Retinal Disease ___ Glaucoma

___ Cataracts ___ Eye Injury ___ Drooping Eyes

Are you pregnant (if applicable)? ____ Yes ____ No

Do you wear glasses? ___ Yes ___ No If YES, how old is your present pair of glasses? _____ Years

Do you wear contacts? ___ Yes ___ No If YES, how old is your present pair of contacts? _____ Weeks

What Brand/Power? _____Are they comfortable? _____ Yes ____ No

Family History (please note any family history – parents, grandparents, siblings, children) for the following conditions

DISEASE/CONDITION	RELATIONSHIP TO YOURSELF
____Blindness	_____
____Cataracts	_____
____Glaucoma	_____
____ Crossed Eyes	_____
____ Macular Degeneration	_____
____ Retinal Detachment/Disease	_____
____ Arthritis	_____
____ Cancer	_____
____ Diabetes	_____
____ Heart Disease	_____
____ High Blood Pressure	_____
____ High Cholesterol	_____
____ Kidney Disease	_____
____ Lupus	_____
____ Thyroid Disease	_____
____ Other	_____

Social History

Do you Drive? ___ Yes ___ No If YES, do you have any visual difficulty when driving? ____ Yes ___ No

Do you use: Tobacco Products ___ Yes ___ No If Yes, type/amount/how long? _____

Alcohol ___ Yes ___ No If Yes, type/amount/how long? _____

Illegal Drugs ___ Yes ___ No If Yes, type/amount/how long? _____

Have you even been exposed or infected with:

Gonorrhea ____ Yes ____ No Hepatitis ___ Yes ___ No

Syphilis ____ Yes ____ No HIV/AIDS ___ Yes ___ No

INFINITY
EYE CARE

INSURANCE SIGNATURE ON FILE

Most insurance companies require, as part of a comprehensive medical eye examination, dilation, screening visual fields, and other ancillary tests. A comprehensive medical eye examination which includes these procedures starts at $150.00. Your insurance carrier will be billed this fee of $150.00, or more, depending on the level of service provided. Refractive and routine services are also not covered services under medical insurance plans. The refraction fee is $35.00.

Additional diagnostic procedures are performed only when medically necessary, i.e. scanning laser retinal imaging, digital retinal photography, advanced threshold visual fields, are not part of the comprehensive examination, and are billed separately to your insurance carrier, if needed.

Contact lens fitting and evaluation fees are a separate and non-covered service by most insurance carriers. The fee varies depending upon the type of contact lens required and the difficulty of the fit.

Your insurance benefit cannot be combined with any other discount or promotion. All insurance carriers are billed under the group practice name, “Infinity Eye Care, PC.”

I authorize the doctor to perform any diagnostic tests necessary to assess the health of my eyes and to bill my insurance carrier for all services rendered. I understand that benefits given are not a guarantee of payment and that I am responsible for any co-payment, deductible, or for any claim denied for payment from my insurance carrier. For Medicare, this form also serves as signed authorization for HFCA form 1500, Block 12 and Block 13.

I authorize Infinity Eye Care, PC and any of its business associates or vendors to communicate with me through mail, or the electronic equivalent. I understand that Infinity Eye Care, PC will not distribute for free, or for sale, any of my personal data. *I authorize Infinity Eye Care, PC to obtain my medication history from secure internet sources.*

ACKNOWLEDGEMENT OF HIPAA: I acknowledge that I have received or been offered a copy of HIPAA Notice of Privacy Practices

Date: _____

Patient: _____

Signature: _____

CONTACT LENS FITTING AGREEMENT

FITTING:

• A contact lens fitting is a separate service not included in a routine eye exam or refraction (prescription) for glasses. An additional fee will be charged. The fee varies depending upon the type of contact lens required and the difficulty of the fit. Some insurance companies may cover a portion of this fee, however most do not. **A member of our staff will review your benefits with you based on your prescription prescribed to you by the doctor today.**

• The fitting fee is payable at the time of service. The fee is non-refundable, and no guarantee is made that an acceptable fit can be achieved. Although it is our desire to succeed with all patients, some will be unable to attain a proper fit or tolerate contacts for varying reasons beyond our control.

• A contact lens prescription is a prescription for a specific lens brand and size. This usually requires "trial fittings" of lenses to determine both the power and fit of the lens and may require multiple visits. You have 45 days from your initial yearly contact lens exam to address any problems and concerns. Failure to make follow up visits to assure proper fit, may result in the denial of the prescription. Patients desiring fitting for additional lenses, i.e. colors, different brands, or prescriptions outside of your first 45 days may be charged an additional fitting fee.

• Some insurance plans limit what brands we can fit you with. These contacts are not guaranteed to fit every person's needs. You do have the option to choose other lenses, however you will be responsible for the cost of the fitting and the contacts themselves.

CONTACT LENS FACTS AND PRECAUTIONS:

• Contact lenses are a medical device regulated by the FDA and must be prescribed and used under the supervision of a licensed ophthalmologist or optometrist.

• Every contact lens is FDA approved for a specific type of wear and replacement program. Failure to follow these guidelines may result in serious vision threatening complications. Failure to follow proper care are sterilization techniques can result in vision threatening complications.

• In order to continue as a contact lens wearer, a yearly eye exam will be required to assure your lenses are well tolerated.

• Should your eye become red or painful while wearing your contacts, they should be removed immediately. If the pain or redness does not resolve within 12 hours you should call the office for an appointment.

Multiple may apply: **CL Teach** -$50 **New Multifocal** -$150 **Previous Multifocal** -$100
Single Vision / Existing patient refit (no changes) - $70

Patient's Name _____

Signature _____

Date _____