Patient History Questionnaire

Today's Date _____

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

Last Name _____ First Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Work Phone _____ Home Phone _____
Date of Birth _____ Occupation _____ Employer _____
Emergency Contact Name _____ Phone Number _____
Date of Last Eye Exam _____ Dilated? Yes/No Referred By _____
Primary Vision Coverage _____ Secondary Coverage _____

Medical Information

How is your general health? _____
Do you take medications for any of these systems? **(Please circle yes or no.)**

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High blood pressure	Yes/No	Eyes	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 _____	Macular degeneration	Yes/No	Relation _____
Diabetes	Yes/No	Relation _____	Retinal detachment	Yes/No	Relation _____
Glaucoma	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 an eye injury? Yes/No Kind _____ Date _____

Do you have glaucoma?	Yes/No	Cataracts?	Yes/No	Dry eyes?	Yes/No
Macular degeneration?	Yes/No	Retinal detachment?	Yes/No	Blurred vision?	Yes/No
Do you wear glasses?	Yes/No	Contact lenses?	Yes/No	Type	_____

Additional information _____

Doctor Use Only

Reviewed by _____ ○ No changes Date _____
Reviewed by _____ ○ No changes Date _____
Reviewed by _____ ○ No changes Date _____

Email:

CONSENT FOR TREATMENT

Dr. Kirk Kvitle/Dr. Jason Kvitle are herewith authorized to render service, medication and treatment as necessary. I assume full financial responsibility for any bills incurred. Dr. Kirk Kvitle/Dr. Jason Kvitle are participating Medicare providers.

INSURANCE RELEASE

I authorize the release of medical information contained in my medical records to family physicians and/or insurance companies. A photocopy of this authorization shall be as valid as the original. I assume responsibility for any balance above insurance.

MEDICARE LIFETIME CONSENT

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Kirk Kvitle/Dr. Jason Kvitle for any services furnished by that physician. I authorize any holder of medical information about me to release to the Health Care Administration and its agents any information needed to determine these benefits or the benefits payable to the related services.

SIGNED_____

DATE_____

MEDICARE NUMBER (IF APPLICABLE)_____

PAYMENT FOR SERVICES IS EXPECTED AT THE TIME SERVICES ARE RENDERED. ARRANGEMENTS SHOULD BE MADE FOR EXCEPTIONS.

ANY ACCOUNT WITH A BALANCE OVER 90 DAYS WILL BE SENT TO COLLECTIONS UNLESS ARRANGEMENTS HAVE BEEN MADE.