# 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 _____

## CONSENT FOR TREATMENT

Dr. Kirk Kvitle/Dr. Jason Kvitle are here with authorized to render services, 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.

## LATE/NO SHOW POLICY & MEDICATION REFILLS

It is the policy of Family EyeCare & Contact Lens Center, LLC that if a patient misses more than three (3) appointments in 1 year without calling to cancel, they will be made walk-in only. A patient is considered "LATE" if they are more than 15 minutes late for their scheduled appointment. It is at the discretion of the provider as to whether the patient can still be seen as they will need to reschedule.

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.

SIGNED: _____

DATE: _____

EMAIL: _____

Your **VISION SERVICE PLAN** offers a benefit of a retinal photograph. The retinal photograph will include digital photos of the two most important portions of the retina, the optic nerve and the macula. The doctors from Family EyeCare recommend this simple photograph to record both normal and abnormal tissue and to be able to monitor it in the future for change. The usual and customary cost for this test is $147.00 however, your vision care plan offers it to you for only $39.00. Your savings in $108.00.

____Yes _____No