

Medical History Questionnaire

Name: _____

Today's Date: ___/___/___

Medical History

DOB: ___/___/___

Do you have any allergies to medications? no yes

If yes, explain: _____

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: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant and/or nursing? no yes

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check Box)

Do you drive? no yes If yes, do you have visual difficulty driving? no yes If yes, please describe: _____

Do you use tobacco products? no yes If yes, type/amount/how long: _____

Do you drink alcohol? no yes If yes, type/amount/how long: _____

Do you use Illegal Drugs? no yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Please turn this form over and complete side two

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?		NO	YES	?
CONSTITUTIONAL				EARS, NOSE, MOUTH, THROAT			
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES				RESPIRATORY			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR/ CARDIOVASCULAR			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Grtty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY			
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BONES/JOINTS/MUSCLES			
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC/HEMATOLOGIC			
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE				Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIC/IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a conditions not listed, please explain & list medications:

Doctor's Signature

Date

(For Office Use Only) I have reviewed and updated the above information. (Please initial & date)

Initial _____ Date _____

Initial _____ Date _____

Initial _____ Date _____

Initial _____ Date _____

Initial _____ Date _____

Initial _____ Date _____

Initial _____ Date _____

Initial _____ Date _____

Initial _____ Date _____

Initial _____ Date _____

Initial _____ Date _____

Initial _____ Date _____

Initial _____ Date _____

Initial _____ Date _____

Initial _____ Date _____

Patient Registration

Patient Information	
<p>Name: _____</p> <p>Circle one: Dr Mr Mrs Ms Miss Jr Sr I II III</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Home phone: () _____ - _____</p> <p>Work phone : () _____ - _____</p> <p>Cell phone: () _____ - _____</p> <p>Circle one of the following that applies to the patient: I am employed: Full time Part time</p> <p>Self employed Homemaker Retired</p> <p>Currently unemployed</p> <p>Employer: _____</p> <p>Occupation: _____</p>	<p>Date of Birth: ____/____/____ Sex: M or F</p> <p>Social Security number: ____/____/____</p> <p>Circle one: I am: Married Single Widowed Domestic Partner</p> <p>If student, circle one: Full time Part time</p> <p>Medical Doctor: _____</p> <p>MD Phone #: _____</p> <p><i>Your email is only used for our office's professional purposes and will never be shared with any outside persons or sources.</i></p> <p>Email: _____</p> <p style="text-align: center;">For New Patients:</p> <p style="text-align: center;">Whom may we thank for referring you?</p> <p style="text-align: center;">_____</p>
Spouse or Parent Information	
<p>Name: _____</p> <p>DOB: ____/____/____</p> <p>Relationship to patient: _____</p> <p>Employer: _____</p> <p>Address: _____</p> <p>Work phone: () _____ - _____</p>	

ADVANCED EYE GROUP, LLC.

206 N. MAIN RD * VINELAND, NJ 08360 * 856-691-0720

STATEMENT OF RESPONSIBILITY/FINANCIAL ASSIGNMENT & RELEASE

IF YOU HAVE HEALTH INSURANCE OF ANY KIND, PLEASE READ OUR POLICY:

We will do everything we can to help you obtain reimbursement from your insurance carrier; however, the basic responsibility is yours. As a courtesy to you, we will send claims to your insurance company. However, we cannot accept the responsibility for negotiating claims with insurance companies or other parties.

Please check with your insurance company to see if a *referral* is required for your visit. If one is needed, it is your responsibility to obtain one *prior* to your visit. If no referral is issued, we will have to reschedule your appointment. I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered. _____

Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claims. You agree to be financially responsible to reimburse all fees for services not collected in full at the date of service should your insurance or vision plan denial in part or in the entire claim. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. _____

I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive, and I agree to make payment in full. _____

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full. _____

If you do not inform us you have a vision plan or medical insurance before services are rendered, we will assume no coverage exists. _____

I agree I am responsible to file my own claim if I discover I have vision or medical benefits after services or products are rendered. _____

I agree this office, with NO EXCEPTIONS will not back date and file claims, post authorize claims, or refund fees after services are rendered due to lack of notification of vision or medical benefits. _____

Patient Signature

Date

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REFRACTION FEE

The refraction is the portion of your comprehensive eye exam in which your eyeglass or contact lens prescription is determined. If your insurance does not provide routine eye exams this fee of \$25 is due at the time services are rendered.

I have been notified that my refraction done today will not/may not be covered by my insurance and I assume responsibility for this fee.

Patient Signature

Date

I have read the above and do not want the refraction portion of my eye exam done today.

Patient Signature

Date

HIPAA Privacy Acknowledgement of Notice of Privacy Practices

I, _____ have been presented with the Notice of Privacy Policy of Advanced Eye Group and have been offered a copy of such policy to keep for my records.

I decline receipt of the written policy _____

Patient Signature

Date

I accepted a copy of the written policy _____

Patient Signature

Date

WITH WHOM DO WE HAVE PERMISSION TO DISCUSS YOUR MEDICAL INFORMATION WITH?

NAME _____ RELATIONSHIP _____ DATE _____

NAME _____ RELATIONSHIP _____ DATE _____

NAME _____ RELATIONSHIP _____ DATE _____