PATIENT INFORMATION

TODAY'S DATE:	LAST NAME:	FIRST:	MIDDLE:
GENDER: ☐M ☐F	MARITAL STATUS: ☐S ☐M ☐D ☐W	SSN:	DATE OF BIRTH:
IF PATIENT IS A MINORRESPONIBLE PARTY/RELATIONSHIP:			
MAILING ADDRESS:		CITY:	ST: ZIPCODE:
HOME PHONE:	CELL:	WORK:	EMAIL:
EMPLOYER:		OCCUPATION	
EMERGENCY CONTACT/RELATIONSHIP:			
COMMUNICATIONS PREFERENCE: ☐EMAIL ☐POSTAL ☐TELEPHONE			

INSURANCE INFORMATION

*IF BILLING INSURANCE PLEASE GIVE THE FRONTDESK ALL INSURANCE CARDS TO BE SCANNED INTO YOUR RECORD!

VISION PLAN

INSURANCE CARRIER:	ID#:	GROUP #:
SUBCRIBER: ☐SELF ☐SPOUSE ☐DEPENDENT(CHILD)		
SUBCRIBER NAME (IF NOT SELF):	DOB:	SSN:
SECONDARY INSURANCE:		

MEDICAL PLAN

INSURANCE CARRIER:	ID#:	GROUP #:
SUBCRIBER: ☐SELF ☐SPOUSE ☐DEPENDENT(CHILD)		
SUBCRIBER NAME (IF NOT SELF):	DOB:	SSN:
SECONDARY INSURANCE:		

LAST EYE EXAM: _____ BY WHOM: _____

YOUR PRIMARY CARE PHYSICIAN: _____

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ TODAY'S DATE: _____/_____/_____

MAIN REASON FOR YOUR VISIT TODAY:

☐ Routine Eye Exam ☐ Exam for Contact Lenses ☐ Medical Condition ☐ Surgery Consultation

☐ Diabetic Exam ☐ Other: _____

CHECK ANY VISION COMPLAINTS THAT YOU ARE CURRENTLY EXPERIENCING:

☐Headache/Migraine ☐Light Sensitivity ☐Dryness ☐Blurred Vision ☐Flashes of light/Floaters

☐Itching/Burning/Red ☐Excessive tearing ☐Foreign Body ☐Loss of Vision ☐Sandy/Gritty Feeling

☐Eye Pain/Swelling ☐Frequent Eye Infections ☐Blindness ☐Other: _____

Which eye: _____ Started_____ Duration (how long) _____

Severity (mild/Mod/Severe) _____ Timing _____Relief Factors: _____

MEDICAL HISTORY

List any injuries, surgeries and/or hospitalization you've had recently (including eye surgeries): _____

_____

List all MEDICATIONS YOU ARE CURRENTLY TAKE: (Including over the counter, vitamins and supplements):

_____ _____ _____

_____ _____ _____

List any allergies to medication: _____

FOR DIABETIC PATIENTS: ☐ TYPE 1 ☐ TYPE 2

Current Diabetic Therapy: ☐Insulin ☐Oral Medications ☐Diet Control

Last HbA1C: _____ Result of last glucose reading? _____

Diabetic Physician: _____

MEDICAL HISTORY QUESTIONNAIRE

REVIEW OF SYSTEMS –DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREA'S:

Constitutional
Fever ☐NO ☐YES
Fatigue ☐NO ☐YES

Ear, Nose, Throat
Hearing Loss ☐NO ☐YES

Cardiovascular
Heart Disease ☐NO ☐YES
Hypertension ☐NO ☐YES
Stroke ☐NO ☐YES

Respiratory
Asthma ☐NO ☐YES
COPD ☐NO ☐YES

Urinary
Kidney Disease ☐NO ☐YES
Urinary Conditions ☐NO ☐YES

Musculoskeletal
Arthritis ☐NO ☐YES
Muscle Pain ☐NO ☐YES

Skin
Rosacea ☐NO ☐YES
Shingles ☐NO ☐YES
Skin Cancer ☐NO ☐YES

Neurological
Multiple Sclerosis ☐NO ☐YES
Headaches ☐NO ☐YES
Seizures ☐NO ☐YES

Psychiatric
Memory Loss ☐NO ☐YES
Depression ☐NO ☐YES

Blood
Anemia ☐NO ☐YES
Cholesterol ☐NO ☐YES

Immunologic
Seasonal Allergies ☐NO ☐YES
Lupus ☐NO ☐YES

Endocrine
Diabetes ☐NO ☐YES
Thyroid ☐NO ☐YES

Gastrointestinal
Intestinal ☐NO ☐YES

Maternity
Pregnant ☐NO ☐YES
Nursing ☐NO ☐YES

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions and list their relation to you:

Ocular Condition	No	Yes	Relation	Medical Condition	No	Yes	Relation
Glaucoma				High Blood Pressure			
Cataracts				Diabetes			
Macular Degeneration				Lupus			
Blindness				High Cholesterol			
Retinal Tear/Detachment				Heart Disease			

SOCIAL HISTORY

SOCIAL HISTORY-This information is kept strictly confidential, however, you may discuss this portion directly with the doctor if you prefer.
☐ I would prefer to discuss my social history information directly with the doctor. (Check box)

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 (check those that apply, if any): ☐Gonorrhea ☐Hepatitis ☐HIV ☐Syphilis ☐Herpies

CURRENT VISION

Do you currently wear glasses? ☐NO ☐YES
If Yes, Do you have difficulty with any of these activities, even with your glasses?

☐Driving ☐Reading ☐Writing/paying bills ☐Watching TV ☐Computer use

☐Recreational Activities ☐Other: _____

Do you wear Contact Lenses: ☐NO ☐YES If yes, what brand of contact lenses do you wear? _____

OFFICE AGREEMENT

NOTICE OF PRIVACY PRACTICES: Peninsula Eye Clinic HIPAA Notice of Privacy Policy has been made available to me.

MEDICARE: Routine eye examinations are a non-covered benefit. Medicare will cover the cost of services only if there is a medical necessity for the exam or test, such as eye infections, cataracts, diabetes, etc. The portion of the eye examination called the refraction is where the doctor takes measurements to determine whether or not to prescribe glasses is always considered routine and is not a covered benefit. The fee for this service is **$45.00** at the time of service.

INSURANCE: Peninsula Eye Clinic will file your claims with your insurance company as a courtesy, but you are ultimately responsible for all fees for both services and materials delivered to you by this office. Verification of eligibility by your insurance company is not a guarantee of payment, coverage, or benefits. Not all services are covered benefits in all vision and insurance plans, and routine eye care and other selected procedures may be specifically excluded, making you responsible for the charges. It is your responsibility what services are covered under your vision and medical policy. If you have any questions whether a service will be covered you are urged to contact your insurance company. If your coverage requires a referral from your primary health care provider to see us, it is your responsibility to obtain that referral prior to your examination.

OFFICE POLICY ON PAYMENT: Unless other payment arrangements are made in advance, Peninsula Eye Clinic requires payment in full for examination fees and all materials at the time of service.

CONTACT LENS FEES: Contact lens examinations will be subject to a contact lens evaluation fee in addition to the exam fee. These fees range from **$95.00 to $120.00**.

AUTHORIZATION TO BILL: I have read and understand the above information and agree to comply with these terms. I authorize my insurance company to make payment directly to Peninsula Eye Clinic for services and/or materials rendered and I authorize the use of this signature on all insurance submissions. I authorize Peninsula Eye Clinic to release information about me or my dependents necessary to process any and all claims for reimbursement on my behalf and/or to secure the payment of benefits by any third party payers, including, but not limited to any to any insurance carrier, Social Security Administration and Worker's Compensation.

AUTHORIZATION TO TREAT: I authorize Peninsula Eye Clinic to furnish optometric care and services, including but not limited to diagnostic tests, examinations, and other medical procedures which are deemed necessary in the course of my care.

PLEASE LIST ANY OTHER PARTIES WHO CAN ACCESS TO YOUR HEALTH INFORMATION:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

SIGNATURE: _____ DATE: _____

PATIENT OR PARENT/GUARDIAN