New patient history questionnaire

Please print the completed form and bring to your appointment. Sending personal health information via email is not secure or recommended.

Thank you for choosing our office for your vision care. In order to provide you with the best care possible, we ask that you answer the questions below. If you prefer, we will be happy to sit down with you to help you complete this form. We are here to assist you!

Name: _____ **Date:** _____
(First) (M.I.) (Last)

I prefer to be called: _____ **Date of Birth:** _____ **Age:** _____ **Occupation:** _____

Gender: Male □ Female □ Email: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone (c): (_____)_____ **Phone (h):** (_____)_____ **Phone (w):** (_____)_____

Vision Plan:_____ **Medical Insurance:**_____

How did you find us? □ insurance/provider list □ drive/walk by □ friend/family _____ **□ other**_____

Have you had any ongoing problems with any of the following systems? Please check (√) all that apply:
PATIENT MEDICAL INFORMATION

_____	gastrointestinal	_____	nervous system	_____	endocrine/glands
_____	ears/nose/throat	_____	urinary tract	_____	blood/lymph
_____	cardiovascular/heart disease	_____	muscles/bones	_____	allergic/immunologic
_____	respiratory	_____	integument/skin	_____	headaches
_____	high blood pressure	_____	cancer	_____	psychiatric/psychological
_____	diabetes (if yes, date of diagnosis: _____)	□ Type I diabetes □ Type II diabetes			

Please describe any health issues: _____

Are you currently taking medication? □ y □ n If yes, please list: _____

Are you allergic to medication? □ y □ n Please list: _____ **Do you use cigarettes/tobacco? □ y □ n**

Name of primary care physician: _____ **Date of last visit:** _____

PATIENT'S EYE HISTORY

Date of last eye exam _____ **Do you wear glasses? □ y □ n Do you wear contact lenses? □ y □ n** ***If yes:*** **□ soft □ rigid**

Please describe any problems with your eyes for which you are seeking treatment today: _____

_____

Do you have any other eye conditions or problems? If so, describe _____

Have you had a serious eye injury or eye surgery (including laser vision correction)? If yes, please describe: _____

_____**date:** _____

Are you using any eye drops (prescription or over-the-counter)? Please list: _____

Check all that apply: □ itchy eyes □ stinging/burning □ flashes/floaters □ eyestrain/eye fatigue □ blurry vision □ red eyes

□ other: _____ **Are you interested in the following: □ new glasses □ contact lenses □ vision correction surgery**

FAMILY EYE & MEDICAL HISTORY

Please check (√) any conditions that have occurred in your immediate family:

_____	glaucoma	relation_____	_____	cataracts	relation_____
_____	macular degeneration	relation_____	_____	diabetes	relation_____
_____	retinal detachment	relation_____	_____	high blood pressure	relation_____

**** CONTINUED ON OTHER SIDE ****

WALTER
Eye Clinic
Est. 1977 TINLEY PARK

FINANCIAL RESPONSIBILITY:
Payment for all professional services rendered is due at the time of service. If you have health insurance, it is your responsibility to ensure we have correct and current information for your insurance plan. It is also your responsibility to pay the copay at the time of service per our contract with your insurance plan. If you are not using health insurance, Walter Eye Clinic offers a self-pay discounted fee schedule. Payment for services rendered is required at the time of service.

_____ _____
Signature of Patient/Responsible Party Date

ASSIGNMENT OF BENEFITS:
I hereby assign all medical benefits, to include major medical benefits, to which I am entitled, to Walter Eye Clinic for services rendered. I hereby authorize and direct my insurance carrier (including Medicare, private insurance and any other vision or medical plan) to issue payment(s) directly to Walter Eye Clinic for health care services provided to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am financially responsible for copay, coinsurance and deductible at the time of service and for any services rendered that are determined to be "non-covered services" by my plan.

I certify that the insurance information I have provided to Walter Eye Clinic is true and that it is my obligation to know my plan's requirements and ensure that they have been fulfilled**. I understand that my insurance(s) may not pay 100% of the amount of the claim for services rendered and that I am responsible for any and all amounts not payable by my insurance(s) that are assigned to me.** I agree to notify Walter Eye Clinic of any changes in the information I have provided. This assignment of benefits will remain in effect until revoked by me in writing to Walter Eye Clinic.

_____ _____
Signature of Patient/Responsible Party Date

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT:
We keep a record of the health care services we provide to you. You may request a copy of your medical record in writing. We will not disclose your record to others unless you direct us to do so or unless legal authorities authorize or compel us to do so. You may request a copy of your medical record or get more information by contacting the Walter Eye Clinic Privacy Officer. Our Notice of Privacy Practices is available at the reception desk and is posted in the clinic. The Notice describes in greater detail how your health information may be used or disclosed, and how you can access your information. You are entitled to a copy of this Notice and it is available at your request.

I acknowledge the Notice of Privacy Practices has been offered to me and is readily available in accordance with the Health Insurance Portability and Accountability Act.

_____ _____
Signature of Patient/Responsible Party Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:
I authorize the release of medical information regarding myself/my dependents and my current condition to my referring, consulting, or treating physicians.

_____ _____
Signature of Patient/Responsible Party Date