PATIENT HISTORY EVALUATION SHEET

Date _____

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

Last Name_____ First Name_____ MI_____

Address _____ City_____ State_____ Zip_____

Email _____

Cell Phone_____ Work Phone_____ Home Phone_____

Date of Birth_____ Occupation_____ Employer_____

Emergency Contact Name_____ Phone Number_____

Date of Last Eye Exam_____ Dialated? *Yes/No*

MEDICAL INFORMATION

How is your general health? _____

Do you take medication 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 any 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 (if yes)* Type_____

Additional information_____

I understand if I fail to pay for any charges owed American Vision Center, I will be responsible for all collection costs incurred.

I have completed the information above to the best of my knowledge. _____
signature

Who may we thank for your referral?_____

INSURANCE INFORMATION

PRIMARY INSURANCE

Primary Holder's Name_____ Ins Co Name_____

Policy Holder's ID #_____ Group_____

Birth date_____ SS#_____ Employer_____

SECONDARY INSURANCE

Primary Holder's Name_____ Ins Co Name_____

Policy Holder's ID #_____ Group_____

Birth date_____ SS#_____ Employer_____

OTHER INSURANCE

Primary Holder's Name_____ Ins Co Name_____

Policy Holder's ID #_____ Group_____

Birth date_____ SS#_____ Employer_____

FINANCIAL RESPONSIBILITY & INSURANCE RELEASE / ASSIGNMENT

I herby authorize American Vision Center to release to my insurance company any information including the diagnosis and the records of any treatment or examination, as well as any optical services, rendered to me. **For billing purposes I understand and authorize the following:**

- Direct my insurance company to issue all payments directly to American Vision Center.
- Any money received from my insurance company over and above my indebtedness will be refunded to me when my account is paid in full.
- I shall be financially responsible for charges regardless of my insurance benefits and for services not covered or paid by my insurance company.
- I shall be responsible for any additional collection charges, legal fees and attorney fees should my account need to be sent to an outside collection agency or when court action is required.

Date:_____ Signed:_____

Date:_____ Witness:_____

MEDICARE RELEASE AND ASSIGNMENT

I request that payment of authorized Medicare benefits be made on my behalf to American Vision Center for services furnished to me by the provider. I authorize any holder of medical information about me to release benefits or the benifits payable for related service.

Date:_____ Signed:_____

SECONDARY INSURANCE

I request that payment of authorized insurance benefits paid by my insurance company be made to either me, or on my behalf, to American Vision Center for services furnished. This authorization is valid for all services furnished until it is revoked.

Date:_____ Signed:_____