Medical History Questionnaire

Name:_____ Today's Date_____
Address:_____ Cell Phone:_____
City/State/Zip:_____ Home Phone:_____
Email Address:_____
Birth Date:____/_____/_____ Last Eye Exam:_____/_____/_____
Emergency Contact:_____ Phone:_____
Name of Medical Doctor:_____ Dr.'s Phone:_____

Medical History

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, cataract, eye infections or eye injury:_____

Are you pregnant and/or nursing? ____ no ____ yes
Do you wear glasses? ____ no ____ yes If yes, how old is your present pair of lenses? _____
Do you wear contact lenses? ____ no ____ yes If yes, how old is your present pair of lenses? _____
Type of contact lenses: ____Rigid ____Soft ____Extended Wear ____Other Are they comfortable?_____

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	____	____	____	M	F	B	S	MGF	MGM	PGF	PGM	Distant
Cataract	____	____	____	M	F	B	S	MGF	MGM	PGF	PGM	Distant
Crossed Eye	____	____	____	M	F	B	S	MGF	MGM	PGF	PGM	Distant
Glaucoma	____	____	____	M	F	B	S	MGF	MGM	PGF	PGM	Distant
Macular degeneration	____	____	____	M	F	B	S	MGF	MGM	PGF	PGM	Distant
Retinal Detachment/Disease	____	____	____	M	F	B	S	MGF	MGM	PGF	PGM	Distant
Rheumatoid Arthritis	____	____	____	M	F	B	S	MGF	MGM	PGF	PGM	Distant
Cancer	____	____	____	M	F	B	S	MGF	MGM	PGF	PGM	Distant
Diabetes	____	____	____	M	F	B	S	MGF	MGM	PGF	PGM	Distant
Heart Disease	____	____	____	M	F	B	S	MGF	MGM	PGF	PGM	Distant
High Blood Pressure	____	____	____	M	F	B	S	MGF	MGM	PGF	PGM	Distant
Kidney Disease	____	____	____	M	F	B	S	MGF	MGM	PGF	PGM	Distant
Lupus	____	____	____	M	F	B	S	MGF	MGM	PGF	PGM	Distant
Thyroid Disease	____	____	____	M	F	B	S	MGF	MGM	PGF	PGM	Distant

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.

Do you Drive? ____ no ____yes If yes, do you have difficulty when driving? ____no ____yes

If yes, please explain_____

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 or infected with: ____Gonorrhea ____Hepatitis ____HIV ____Syphilis

Review of Systems

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	____	____	____
INTEGUMENTARY(Skin)	____	____	____
NEUROLOGICAL	____	____	____
Headaches	____	____	____
Migraines	____	____	____
Seizures	____	____	____
EYES			
Loss of Vision	____	____	____
Blurred Vision	____	____	____
Distorted Vision/Halos	____	____	____
Loss of Side Vision	____	____	____
Double Vision	____	____	____
Dryness	____	____	____
Mucous Discharge	____	____	____
Redness	____	____	____
Sandy or Gritty Feeling	____	____	____
Itching	____	____	____
Burning	____	____	____
Foreign Body Sensation	____	____	____
Excess Tearing/Watering	____	____	____
Glare/Light Sensitivity	____	____	____
Eye Pain or Soreness	____	____	____
Chronic Infection of Eye/Lid	____	____	____
Sties or Chalazion	____	____	____
Flashes/Floaters in Vision	____	____	____
Tired Eyes	____	____	____
ENDOCRINE			
Thyroid/Other Glands	____	____	____

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	____	____	____
Sinus Congestion	____	____	____
Runny Nose	____	____	____
Post-Nasal Drip	____	____	____
Chronic Cough	____	____	____
Dry Throat/Mouth	____	____	____
RESPIRATORY			
Asthma	____	____	____
Chronic Bronchitis	____	____	____
Emphysema	____	____	____
VASCULAR/CRADIOVASCULAR			
Diabetes	____	____	____
Heart Pain	____	____	____
High Blood Pressure	____	____	____
Vascular Disease	____	____	____
GASTROINTESTINAL			
Diarrhea	____	____	____
Constipation	____	____	____
GENITOURINARY			
Genitals/Kidney/Bladder	____	____	____
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	____	____	____
Muscle Pain	____	____	____
Joint Pain	____	____	____
LYMPHATIC/HEMATOLOGIC			
Anemia	____	____	____
Bleeding Problems	____	____	____
ALLERGIC/IMMUNOLOCIC	____	____	____
PSYCHIATRIC	____	____	____

INSURANCE INFORMATION AND SIGNATURE ON FILE FORM

Patient Name: _____ Today's Date_____
Occupation:_____ Marital Status: Single Married Widowed
Emergency Contact_____ Phone: _____
Parent/Guardian_____ Phone: _____
Referred by:_____

Please read before signing:

You are responsible for all charges if you do not get prior approval from your insurance company or necessary referrals. You will be asked to pay for any non-covered services, co-payments, and deductibles at the time of your visit. It is your responsibility to verify that we are on your insurance company's participating provider list. We will gladly file your information to your insurance company for payment, but it is ultimately your responsibility for payment in full. The doctor's professional fees are due at the time of service. Ancillary testing (Visual Fields, OCT, Photos, etc) is not part of a routine eye exam. Non-refraction diagnosis's may not be included or covered in routine exams. Payment can be made by cash, check, Visa, Master Card or Discover Card.

(Please notify us if you have a secondary or other insurance)

Health Insurance			Vision Insurance		
Company:			Company:		
Plan number:			Plan number:		
Group number:			Group number:		
Insured name: (if not patient)		Date of Birth:	Insured name: (if not patient)		Date of Birth:
Relationship to patient:			Relationship to patient:		
Address of Insured:			Adddress of Insured:		
City:	State:	Zip:	City:	State:	Zip

Note:

Vision insurance usually covers the cost of a routine eye examination for glasses or contacts. Your health insurance usually covers the the cost of a health based examination. If you have any questions please ask.

Insurance Authorization:

I authorize the release of medical or other information to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment (Box 12). I authorize payment of medical benefits to the undersigned physician or supplier for service (Box 13). I read and understand all information on this form.

Signature of Patient: _____ Date: _____

Notice of Privacy Practices

This notice describes privacy practices of Knox Eyecare, PC. This notice includes Bradley Knox, O.D and all employees of Knox Eyecare, PC. All of our staff may have access to information in your chart for treatment, payment, and health care operations. This notice applies to any volunteer trainee we allow to help you while seeking services from us. We reserve the right to revise or amend our notice of privacy practices without additional notice to you. Any revision or amendment to this notice will be effective for all of your records our practice has created to maintain in the past, and for any of your records we may create or maintain in the future.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

For Treatment: We may use medical information about you to provide you with medical treatment or services without consent or authorization unless otherwise required by state law. We may disclose medical information about you to health care providers who are involved in taking care of you, whether or not they are affiliated with us.

For Payment: We may use and disclose Medical information about you without consent or authorization so that the treatment and services you receive from us may be billed to and payment may be collected from you, an insurance company, or third party.

For Healthcare Operations: We may disclose medical information about you without consent or authorization for health care operations.

Appointment Reminders: We may use and disclose medical information to contact you by mail or phone to remind you that you have an appointment, unless you tell us in writing.

Individuals involved in your care or payment for your care: We may release medical information about you to a family member who is involved in your medical care without consent or authorization. We may also give medical information, including prescription information or information concerning your appointments to friends who are involved in your care of payment.

As required by law: We will disclose medical information about you to do so by federatl, state, or local law without consent or authorization. To avert serious threat to health or safety: We may disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Right to inspect and copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. If you with a copy of medical information, you must request in writing and you may be charged a fee for the costs of copying, mailing, and other supplies associated with your request.

Right to request an amendment: If you feel that medical information we have about you is incorrect or incomplete, you may ask to amend the information. We may deny the request.

Right to accounting of disclosures: You have the right to request an "accounting of disclosures." You must submit your request in writing. Your request must state a time period which may not be longer than 6 years. The first list within a 12 month period will be free, additional lists will have a fee assessed to them.

Right to request restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. We are not required to agree with your request. To request restrictions, you must make your request in writing.

Right to request confidential communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request in writing.

Right to a paper copy of this notice: You have the right to a paper copy of this notice.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with us, submit your complaint in writing to Bradley Knox, O.D. You will not be penalized for filing a complaint.

If you provide us permission to use or disclose medical information about you, you have the right to revoke your permission. This must be submitted in writing. You understand that we are unable to take back any disclosures we have already made with your permission

Acknowledgement

I acknowledge that on ____ day of _____,201__, I received a copy of Dr. Bradley Knox, O.D. and Knox Eyecare, PC Notice of Privacy Practices.

Dated this ____ day of _____, 201__

_____

or _____

Legal Guardian or Personal Representative
(or other relationship)