

PATIENT HISTORY FORM



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GENERAL INFORMATION

First, MI, Last, Preferred Name _____

Street Address _____

City, State, Zip _____

Phone, Type _____

Phone 2, Type _____

Email _____ Preferred Contact Method _____ Phone 1 | Phone 2 | Email | Text

Patient Social Security Number _____

Date of Birth _____

Patient Sex _____ Male | Female

Primary Care Physician _____

Occupation/Employer _____ full-time | part-time

Marital Status _____ Married | Single | Divorced | Legally Separated | Widowed

Primary Language, Race, and Ethnicity _____ I refuse to disclose this info (initial here)

Mother's Name / Birthday / Primary Phone Number: _____

Father's Name / Birthday / Primary Phone Number: _____

Family Members / Siblings: _____

How did you hear of our office? (Circle Primary Source) WKYM | Z93 | WANY | The Outlook | Clinton Co News | Phone Book | Internet | Facebook

Were you referred to our office by a doctor/patient or friend? Yes | No If so, who? _____

EYE HISTORY/CURRENT SYMPTOMS

Date of Last Eye Exam _____

Currently Wear Glasses? Yes | No _____

Currently Wear Contacts? Yes | No _____

If yes, what brand of contacts: _____

How many hours a day do you use a computer? _____

Do you regularly wear sunglasses? Yes | No _____

Do you use over the counter readers? Yes | No _____

Do you drive? Yes | No _____

Do you have visual difficulty when driving? Yes | No _____

If Yes, Please explain: _____

Have you or a family member experienced, or been treated for any of the following?

Circle all that apply. None applicable

Cataracts myself | mother | father | grandparents | other family _____

Crossed Eye myself | mother | father | grandparents | other family _____

Glaucoma myself | mother | father | grandparents | other family _____

LASIK or RK myself | mother | father | grandparents | other family _____

Lazy Eye myself | mother | father | grandparents | other family _____

Macular Degener. myself | mother | father | grandparents | other family _____

Retinal Detach. myself | mother | father | grandparents | other family _____

Other Eye Conditions? _____

Are you currently experiencing, or have experienced, any of the following? Circle all that apply:

Blurry Vision – Distance	Blurry Vision – Near	Blurry Vision – Computer	Burning
Discharge	Double Vision	Dryness	Excess Tearing/Watering
Eye Infection	Eye Pain or Soreness	Floater or Spots	Halos
Headaches	Itching	Light Flashes	Light Sensitivity
Redness	Sandy or Gritty Feeling	Other _____	

INSURANCE/PAYMENT INFORMATION

Do you have vision insurance? Yes | No _____ Do you have medical insurance? Yes | No _____

How will you be paying today? Cash | Check | Credit Card | Gift Certificate _____

If patient is a minor, what parent/guardian's name would you like them primarily listed under? _____

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply. None

AIDS/HIV	myself mother father brother sister mom's grandma mom's grandpa dad's grandma dad's grandpa aunt uncle
Allergies	myself mother father brother sister mom's grandma mom's grandpa dad's grandma dad's grandpa aunt uncle
Arthritis	myself mother father brother sister mom's grandma mom's grandpa dad's grandma dad's grandpa aunt uncle
Asthma	myself mother father brother sister mom's grandma mom's grandpa dad's grandma dad's grandpa aunt uncle
Blood/Lymph	myself mother father brother sister mom's grandma mom's grandpa dad's grandma dad's grandpa aunt uncle
Cancer	myself mother father brother sister mom's grandma mom's grandpa dad's grandma dad's grandpa aunt uncle
Diabetes	myself mother father brother sister mom's grandma mom's grandpa dad's grandma dad's grandpa aunt uncle
Ears/Nose/Throat	myself mother father brother sister mom's grandma mom's grandpa dad's grandma dad's grandpa aunt uncle
Gastrointestinal	myself mother father brother sister mom's grandma mom's grandpa dad's grandma dad's grandpa aunt uncle
Heart Disease	myself mother father brother sister mom's grandma mom's grandpa dad's grandma dad's grandpa aunt uncle
High Blood Press	myself mother father brother sister mom's grandma mom's grandpa dad's grandma dad's grandpa aunt uncle
High Cholesterol	myself mother father brother sister mom's grandma mom's grandpa dad's grandma dad's grandpa aunt uncle
Kidney Disease	myself mother father brother sister mom's grandma mom's grandpa dad's grandma dad's grandpa aunt uncle
Lupus	myself mother father brother sister mom's grandma mom's grandpa dad's grandma dad's grandpa aunt uncle
Neurological	myself mother father brother sister mom's grandma mom's grandpa dad's grandma dad's grandpa aunt uncle
Psychiatric	myself mother father brother sister mom's grandma mom's grandpa dad's grandma dad's grandpa aunt uncle
Seizures	myself mother father brother sister mom's grandma mom's grandpa dad's grandma dad's grandpa aunt uncle
Skin Conditions	myself mother father brother sister mom's grandma mom's grandpa dad's grandma dad's grandpa aunt uncle
Stroke	myself mother father brother sister mom's grandma mom's grandpa dad's grandma dad's grandpa aunt uncle
Thyroid	myself mother father brother sister mom's grandma mom's grandpa dad's grandma dad's grandpa aunt uncle

Do you currently take any medications, vitamins, herbs? Yes | No **(We can scan your list if you have it!)**

Are you allergic to any medications? Yes | No **If yes, please list below:**

Height: **Weight:** I refuse to disclose this info (initial here) **Are you pregnant or nursing?** Yes | No

Do you use tobacco products? Yes | No **If yes, what kind/how much/how long?**

If no, did you ever? Yes | No

Have you ever been exposed to or infected with (please circle)? Gonorrhea | Hepatitis | HIV | Syphilis

OFFICE POLICIES

1. Payment for services is expected at the time the service is rendered. Glasses and/or contact lenses will be ordered after half down of product total is received in our office and must be paid in full before they can leave our office. We are happy to discuss payment plans if you have a need.
2. Please present all insurance cards to our receptionist at each visit so we can verify coverage and benefits. Authorization and Assignment: I hereby authorize the release of medical information to my insurance company and assign to Vision Care PSC and Dr. Matt Hesse all payment for services rendered to me or my dependents. This assignment will remain in effect until revoked by me in writing. A copy of this authorization may be used in place of the original. Insurance claims will be filed only if our office is a participating provider for my plan; however, it is my responsibility to know my covered benefits. Should my insurance not reimburse the office in a timely manner, I am responsible for the balance.
3. In accordance with KY State Law, eyeglass prescriptions are valid for two (2) years. In order to protect the health of your eyes and in accordance with KY State Law, contact lens prescriptions are valid for one (1) year only.
4. The undersigned understands and agrees that the account balance is due, in full, upon receipt of a statement if received. If the account is not paid in full within 90 days from the date the statement is received, the undersigned agrees to be liable for all costs of collection, including attorney's fees and court costs

If you have any questions concerning any of the above policies, please see the receptionist for further explanation. **Additionally, I acknowledge that I have had the opportunity to review the notice of privacy practices for Vision Care.**

(Sign)

(Date)