PATIENT HISTORY FORM

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 I 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**

Condition					
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	Floaters 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 | maternal grandma | maternal grandpa | paternal grandma | paternal grandpa | aunt | uncle
Allergies	myself | mother | father | brother | sister | maternal grandma | maternal grandpa | paternal grandma | paternal grandpa | aunt | uncle
Arthritis	myself | mother | father | brother | sister | maternal grandma | maternal grandpa | paternal grandma | paternal grandpa | aunt | uncle
Asthma	myself | mother | father | brother | sister | maternal grandma | maternal grandpa | paternal grandma | paternal grandpa | aunt | uncle
Blood/Lymph	myself | mother | father | brother | sister | maternal grandma | maternal grandpa | paternal grandma | paternal grandpa | aunt | uncle
Cancer	myself | mother | father | brother | sister | maternal grandma | maternal grandpa | paternal grandma | paternal grandpa | aunt | uncle
Diabetes	myself | mother | father | brother | sister | maternal grandma | maternal grandpa | paternal grandma | paternal grandpa | aunt | uncle
Ears/Nose/Throat	myself | mother | father | brother | sister | maternal grandma | maternal grandpa | paternal grandma | paternal grandpa | aunt | uncle
Gastrointestinal	myself | mother | father | brother | sister | maternal grandma | maternal grandpa | paternal grandma | paternal grandpa | aunt | uncle
Heart Disease	myself | mother | father | brother | sister | maternal grandma | maternal grandpa | paternal grandma | paternal grandpa | aunt | uncle
High Blood Press	myself | mother | father | brother | sister | maternal grandma | maternal grandpa | paternal grandma | paternal grandpa | aunt | uncle
High Cholesterol	myself | mother | father | brother | sister | maternal grandma | maternal grandpa | paternal grandma | paternal grandpa | aunt | uncle
Kidney Disease	myself | mother | father | brother | sister | maternal grandma | maternal grandpa | paternal grandma | paternal grandpa | aunt | uncle
Lupus	myself | mother | father | brother | sister | maternal grandma | maternal grandpa | paternal grandma | paternal grandpa | aunt | uncle
Neurological	myself | mother | father | brother | sister | maternal grandma | maternal grandpa | paternal grandma | paternal grandpa | aunt | uncle
Psychiatric	myself | mother | father | brother | sister | maternal grandma | maternal grandpa | paternal grandma | paternal grandpa | aunt | uncle
Seizures	myself | mother | father | brother | sister | maternal grandma | maternal grandpa | paternal grandma | paternal grandpa | aunt | uncle
Skin Conditions	myself | mother | father | brother | sister | maternal grandma | maternal grandpa | paternal grandma | paternal grandpa | aunt | uncle
Stroke	myself | mother | father | brother | sister | maternal grandma | maternal grandpa | paternal grandma | paternal grandpa | aunt | uncle
Thyroid	myself | mother | father | brother | sister | maternal grandma | maternal grandpa | paternal grandma | paternal 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 accoradance 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 they are required to reimburse Vision Care PSC the collection fees of any collection agency, which shall be based on a percentage at a maximum rate of 33.3% of the amount due at the time your account is placed with a collection agency, and all costs and expenses incurred for any collection efforts on your account, including reasonable attorney's fees incurred by the collection agency. This contract shall cover all medical treatment, services and products until revoked by either party in writing.

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) ____________