PATIENT INFORMATION QUESTIONNAIRE

Last Name: _____ **First**_____ **M.I.**____ **Today's Date:** _____
Nickname:_____ **(Gender: M F)** **Occupation:**_____

Address: _____ **Home Phone:**_____

City: _____ **State:** _____ **Zip:** _____ __ **Cell Phone:**_____

Date of Birth: ____/____/____ **SSN**_____-_____-_____ **Work Phone:** _____

Parent/Guardian (if applicable)_____ **E-Mail:**_____

Primary Care physician: _____ **Last Eye Exam:** _____

Referred by:_____

HIPAA Notice and Acknowledgement

I acknowledge that I have been provided the HIPAA Notice of Privacy Practices ___Yes ____No

Chief Complaint: What is your primary reason for this visit? _____

_____

Are you experiencing any of the following ocular or visual symptoms? (Check all that apply)

Blurred Vision	____	Light Sensitivity	____	Reduced Night Vision	____
Burning Eyes	____	Itchy, Watery Eyes	____	Reduced Side Vision	____
Excessive Tearing	____	Dry, Gritty Feeling	____	Halos around Lights	____
Noticeable Redness	____	Pain or Discomfort	____	Flashes or Flickers	____
Double Vision	____	New Floaters/Spots	____	Loss of Vision	____

Have you ever been diagnosed with, or treated for, any of the following ocular conditions?

Retinal Detachment	____	Ocular Infections	____	Lazy or Turned Eye	____
Cataracts	____	Glaucoma	____	Styes, Inflamed Lids	____
Macular Degen.	____	Disease of Retina	____		

Do you now wear glasses? _____ If so, how old are they? _____
How is your vision with them? _____ Are they comfortable? _____
What type? ____ Readers ____Distance ____ Bifocal ____ Trifocal ____Progressive

ATTENTION CONTACT LENS PATIENTS:

A contact lens fitting is a professional service separate from the routine vision exam. The fitting includes the trial lenses and any follow-up appointments to provide you with a contact lens prescription. By signing below, you acknowledge that you can use your insurance benefits to cover the contact lens fitting, **OR** you will pay for the contact lens fitting at the time of service.

Signature (patient/ responsible party)_____ Date_____

Do you currently wear contact lenses?_____ What type/brand?_____ Hours per day?_____

Do you use a computer?_____ How many hours per day? _____
Any previous surgeries or injuries to your eyes?_____ If so, please describe_____

_____

Using any ocular medicines? _____ Please list if known: _____
What hobbies, activities, and/or sports do you enjoy? _____

Would you be willing to provide feedback to us on your experience today via a text message or e-mail survey? ____Yes ____No

PATIENT INFORMATION QUESTIONNAIRE

Medical History:

Do you have any allergies to medicines?_____ If so, please list: _____

Are you taking any Rx or OTC medicines?_____ If so, please list: _____

_____

Any previous injuries, surgeries, or hospitalizations? _____

Are you pregnant or nursing? _____ If pregnant, list due date:_____

Have you been diagnosed with or treated for any of the following problems? (Check all that apply)

Allergy Food ____ Seasonal____

Cardiovascular
- Heart Problems ____
- High Blood Pressure ____

Constitutional
- Fever ____
- Weight Gain ____
- Weight Loss ____
- Dizziness/Fainting ____

Endocrine
- Diabetes ____
- Thyroid Disorder ____
- Elevated Cholesterol ____

Gastrointestinal
- Gastrointestinal Disorder ____
- Hepatitis ____
- Gall Bladder ____
- Ulcers ____

Genitourinary
- Bladder Infection ____
- Kidney Stones ____

Cranial/Facial
- Chronic Cough ____
- Dry Mouth ____
- Sinus Infection ____
- Ear Infection ____
- Hearing Loss ____

Hematologic/Lymphatic
- Anemia ____
- Clotting/Bleeding Disorders ____

Immunologic
- HIV/AIDS ____
- Syphilis ____
- Lupus ____
- Mononucleosis ____
- Shingles ____

Musculoskeletal
- Arthritis ____
- Joint Pain ____
- Muscle Pain ____

Neurological
- Headaches ____
- Migraines ____
- Seizures ____
- Bell's Palsy ____
- CP/MS/MD/MG ____

Psychiatric
- Depression ____
- ADD/ADHD ____
- Alzheimers/Dementia___

Respiratory
- Asthma ____
- Chronic Bronchitis ____
- Emphysema, COPD ____
- Tuberculosis ____

Social History:

Do you drive? ____yes ____No If yes, are you having any visual difficulties? _____

Do you use tobacco products? ____Yes ____No If so, how often? _____

Do you use alcohol? ____Yes ____No If so, how often? _____

Do you have a history of drug or alcohol abuse? ____Yes ____No If yes, how long? _____

Have you ever been exposed to HIV or other sexually transmitted diseases? ____Yes ____No

Family Medical History:

In your immediate family, is there any history of the following conditions?

Blindness: Injury___ Disease____	Relationship: _____
Turned or Lazy Eyes ____	Relationship: _____
Cataracts ____	Relationship: _____
Glaucoma ____	Relationship: _____
Macular Degeneration ____	Relationship: _____
Retinal Detach/Disease ____	Relationship: _____
Arthritis ____	Relationship: _____
Cancer ____	Relationship: _____
Diabetes ____	Relationship: _____
Heart Disease ____	Relationship: _____
High Blood Pressure ____	Relationship: _____
Kidney Disease ____	Relationship: _____
Lupus ____	Relationship: _____
Thyroid Disease ____	Relationship: _____

PATIENT INFORMATION QUESTIONNAIRE

Patient Insurance Information

Vision Plan or Medical Insurance being billed today:

Primary's Name: _____ Primary's DOB: _____/_____/_____

Name of Plan or Insurance: _____ Primary's Employer: _____

Member ID or SSN Number: _____ Group Number: _____

Medical Consent to Treatment

The doctor at Steed Family Eyecare is licensed to provide both routine vision exams and medical eye exams. If you are here today for a routine vision exam and your complaint or initial assessment indicates that there is a significant medical condition that requires treatment, you will be either provided with appropriate treatment today; referred to the appropriate specialist for treatment; or rescheduled for a medical examination. Steed Family Eyecare is not a contracted provider for medical visits so the charges for your visit will be payable at the time of service. The doctor will discuss any such condition with you prior to initiating medical treatment, and it is your responsibility to consent to treatment or request referral to the appropriate specialist.

Acknowledgements and Signature

I acknowledge that the health and insurance information I have provided above is true and correct to the best of my ability. I authorize payment of any vision or medical benefits I may be eligible for directly to Steed Family Eyecare. **I agree that if my employer, insurance carrier, or plan sponsor denies payment to all or any part of my claim, I will be financially responsible for all outstanding charges.** I acknowledge that authorization obtained at the time of service does not guarantee payment, and any services not covered by insurance will be billed to me. In the event it becomes necessary to place any unpaid balances I am responsible for in collection, I agree to pay any collection fees, reasonable attorney fees, filing fees, and other costs the court determines are proper. I have read the conditions of service, and as the Patient or the Patient's Authorized Representative I hereby accept these terms.

Signature of Patient or Responsible Party _____ **Date:** _____