Wing EYECARE

PATIENT HISTORY QUESTIONNAIRE

(completion required at each patient appointment)

Welcome to our office

Title ( ) Last name _____ First name _____ MI _____ Date _____
(Mr., Mrs., Ms., Miss, Dr.)

Name you wish to be called _____ E-Mail _____

Home Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ SSN _____ Referred By _____

Employer/School _____ Occupation _____

(Please mark preferred)
☐ Cell _____
☐ Home _____
☐ Work _____

Name of Parent, Legal Guardian or Spouse _____

Name of family members whom we have provided care _____

Insurance Company _____ ID# _____

Subscriber name _____ Relationship to patient _____

Subscriber Birthdate _____

Race (Optional):

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White or Caucasian

Ethnicity (Optional):

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Preferred Language: _____

Medical History / Review of Systems:

List any medications you are now taking (including eye drops, birth control pills, vitamins or over the counter medications):

_____

_____

Are you allergic to any medications? ☐ Yes ☐ No Please list: _____

Primary Care Physician: _____ Pediatrician: _____

Preferred Pharmacy: _____ Location: _____ Phone: _____

Do you have or have you ever had any of the following problems:

☐ No ☐ Yes Asthma/COPD
☐ No ☐ Yes Diabetes
☐ No ☐ Yes High Blood Pressure
☐ No ☐ Yes High Cholesterol
☐ No ☐ Yes Thyroid Problems
☐ No ☐ Yes Arthritis
☐ No ☐ Yes Chronic fever, unexpected weight loss/gain, fatigue
☐ No ☐ Yes Ear/nose/throat (hearing loss, sinus)
☐ No ☐ Yes Endocrine Problems

☐ No ☐ Yes Gastrointestinal Problems (ulcer, abdominal pain, diarrhea)
☐ No ☐ Yes Heart Problems
☐ No ☐ Yes Musculoskeletal Problems
☐ No ☐ Yes Neurologic (numbness, weakness, headaches, prior stroke)
☐ No ☐ Yes Psychiatric Problems (depression, anxiety)
☐ No ☐ Yes Respiratory Problems (shortness of breath, wheezing)
☐ No ☐ Yes Seasonal Allergies
☐ No ☐ Yes Skin Problems (rashes, excessive dryness, rosacea)
☐ No ☐ Yes Urinary Problems (pain or discomfort, blood in urine)

☐ Pregnant/Nursing ☐ Other Condition/Illness _____

List any previous major injuries/surgeries/hospitalizations: _____

Eye History: Do you have or have you ever had any of the following problems:

☐ Blurred Vision ☐ Cataracts ☐ Double Vision ☐ Dry Eye ☐ Eye Injury ☐ Eye Surgery ☐ Flashes ☐ Floaters ☐ Glaucoma
☐ Lazy/Crossed Eye ☐ Loss of Vision ☐ Macular Degeneration ☐ Migraine/Headache ☐ Retinal Detachment

Family History (Mother, Father, Grandparents, Siblings)

☐ Blindness ☐ Cataract ☐ Glaucoma ☐ Lazy/Crossed Eye ☐ Macular Degeneration ☐ Retinal Detachment
☐ Diabetes ☐ High Blood Pressure ☐ Other Eye Disease or Condition: _____

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Marital Status: ☐ Single ☐ Married ☐ Other

Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No If yes, please describe: _____

Smoking History

☐ Current Every Day Smoker
☐ Current Some Day Smoker
☐ Former Smoker
☐ Never Smoker
☐ Smoker (Current Status Unknown)

Do you drink alcohol? ☐ Yes ☐ No _____

Do you use illegal drugs? ☐ Yes ☐ No _____

Have you ever been exposed to or infected with: ☐ HIV ☐ Hepatitis

If patient is 18 or under, please complete:

Any prenatal, perinatal, or postnatal problems? ☐ Yes ☐ No _____

Any developmental problems? ☐ Yes ☐ No _____

Do you have any concerns with your child's school performance? _____

Last eyecare provider: _____ Date of last eye exam _____

Are you currently having eye or vision problems? ☐ Yes ☐ No

If yes, please explain _____

Do you wear glasses? ☐ Yes ☐ No How old are they? _____ Are they bifocals? ☐ Yes ☐ No Are they for ☐ Reading ☐ Distance ☐ Both

Have you ever worn contact lenses? ☐ Yes ☐ No If yes, when were they prescribed? _____

Do you wear contacts now? ☐ Yes ☐ No If not, why did you quit? _____

Are you interested in wearing contact lenses? ☐ Yes ☐ No If yes, please read the following information regarding contact lenses.

Wing Eyecare prescribes quality contact lenses to improve your vision and your lifestyle. Contact lenses are FDA regulated medical devices that can cause discomfort, infections, and even permanent vision loss if not cared for properly. New and existing contact lens wearers require additional time and testing during an eye examination to minimize the risk of serious eye problems. This additional testing is only done for contact lens wearers, not for patients who do not wear contact lenses. For this reason, there are additional contact lens evaluation and services fees for new and existing contact lens wearers. Your contact lens evaluation and services fee includes:

1. Specific curvature measurements of the corneas
2. Evaluation of current and new lenses to ensure optimal fit, vision and comfort
3. Medical assessment of the cornea, tear film and conjunctiva as they relate to contact lens wear
4. Instructions regarding safe contact lens wear, care and proper cleaning and solutions
5. Contact lens follow up care for 1 year

If you have any questions, please do not hesitate to speak with your doctor.

Payment for all services and products is the responsibility of the patient.
I agree to pay all copays, deductibles, co-insurances and non-covered services as determined by my insurance company.
I understand there is a returned check fee applied to every returned check.
I agree to pay an additional collection fee for all accounts not paid in the time stated on the final monthly statement.
I authorize the release of medical information concerning my illness and treatment by Wing Eyecare to my insurance company.
I also authorize the release of my personal medical information to any doctor whom I may be referred to.
I understand verification of eligibility is not a guarantee of payment as stated by my insurance company.
I authorize payment of my insurance benefits to Wing Eyecare.

We will file all insurance forms if Wing Eyecare is a participating provider for your plan.
We will supply you with an itemized statement which you may submit to your insurance carrier.
PAYMENT IN FULL IS REQUIRED AT TIME OF SERVICE

_____ Signature of patient or legal guardian

_____ Today's Date

Updated May 2011

Consent to Use and Disclosure

All patients must sign consent to the use and disclosure of protected health information for the purpose of treatment, payment and conducting the day-to-day operations of Wing Eyecare.

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Wing Eyecare for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Wing Eyecare. I understand that diagnosis or treatment of me by a Wing Eyecare physician may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Wing Eyecare is not required to agree to the restrictions that I may request. However, if Wing Eyecare agrees to a restriction that I request, the restriction is binding on Wing Eyecare and my physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that my physician or Wing Eyecare has taken action in reliance on this consent.

My protected health information means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I request that payment of Authorized Medicare allowable benefits be made to Wing Eyecare for any services furnished to me by Wing Eyecare. I also authorize claims to be filed electronically.

I understand that I am responsible for co-pays and deductibles as well as services and materials not covered by my insurance plan.

I understand I have a right to review Wing Eyecares Notice of Privacy Practices prior to signing this document. Wing Eyecares Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Wing Eyecare. The Notice of Privacy Practices for Wing Eyecare is also provided in the office by the receptionist area and on the Wing Eyecare website at www.Wingeyecare.com. This Notice of Privacy Practices also describes my rights and Wing Eyecare's duties with respect to my protected health information.

Wing Eyecare reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Wing Eyecare's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative	Relationship	Date

Wing Eyecare
Privacy Compliance Official

I have reviewed both sides of this document and there have been no changes.

Form Date	Todays Date	Signature of patient or Personal Representative