Medical History Questionnaire

Name: ______________________________ Today's Date: ______________

Address: ______________________________ Home Phone: ______________

City: ______________ State: ______ Zip: __________ Cell Phone: ______________

Birth Date: ______________ Social Security #: ______________ Texting OK: Yes ________ No ________

Name of Primary Care Doctor: ______________________________ Occupation: ______________

E-Mail: ______________________________ How did you hear about us? ______________

Male __________ Female __________ Race: ______________

Your Medical History

Please list any allergies you have to medications: ______________________________

List any medications you take and the condition you are taking them for: ______________________________

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List any major eye trauma, surgery or disease you have or have had in the past: ______________________________

____

Family Medical History

Please list any family members with high blood pressure and/or heart disease: ______________________________

Please list any family members with diabetes: ______________________________

Please list any family members with ocular disease: ______________________________

Information for Patients Under 18

Guardian's Name: ______________________________ Birth Date: ______________

Social Security #: ______________ Address (if different): ______________________________

Insurance Information/Medicare Information

Name of Primary Insurance Holder (not necessarily the patient - please ask if you have questions):

______________________________ Birth Date: ______________ Social Security #: ______________

INSURANCE HOLDER (NOT INSURANCE)

I request that payment of authorized Medicare Insurance benefits be made either to me or on my behalf to **THE EYE GUYS** for any services furnished to me. I understand that Medicare specifically covers at 80% and that I am responsible for 20% of the allowable charges. If not paid in office, I understand I will be billed. Private insurance will be billed and patient responsibility, not paid in office at time of service, will be billed.

Signature: ______________________________

ACKNOWLEDGMENT
OF
PRIVACY PRACTICES

The law requires that The Eye Guys make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ I have read or had explained to me The Eye Guys' Notice of Privacy Practices and agree to continue my care with The Eye Guys under said terms.
- ☐ I was given the opportunity to read The Eye Guys' Notice of Privacy Practices and declined but wish to continue my care with The Eye Guys under the terms of The Eye Guys' privacy policies.
- ☐ I have read or had explained to me The Eye Guys' Notice of Privacy Practices and do not wish to continue my care with The Eye Guys under said terms.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care or other reason described as:

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I HAVE READ AND UNDERSTAND THIS FORM.
I AM SIGNING IT VOLUNTARILY.

PATIENT ______________________________ DATE______________________________

If you are signing as a personal representative of the patient, please indicate your relationship.

REPRESENTATIVE______________________________ RELATIONSHIP TO PATIENT ____________