New Vision Eyecare - Patient Questionnaire

Name: _____ Sex: M F DOB: _____/_____/_____ Today's Date: _____/_____/_____

Street Address: _____ City: _____ State: _____ ZIP: _____

Cell Phone: _____ Home Phone: _____ Email: _____

Social Security #: _____-_____-_____ Occupation: _____ Guardian (if Applicable) _____

Medical Dr: _____ Vision insurance Carrier: _____ Member ID #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____ Relationship to Patient: _____

Systemic Health; *if (yes) please circle which one*	Yes	No	**Personal Ocular History**	Yes	No
Constitutional (develop. Disabilities, fatigue syndrome)			Blurry vision (wearing current GLs or CLs)		
Ear/Nose/Throat (Hearing Loss, Sinusitis, Dry Mouth, Laryngitis)			Dry or Watery Eyes		
Neurological (MS, Epilepsy, CP, Tumor, Stroke, Migraine)			Double Vision		
Psychiatric (Depression, ADD anxiety, Bipolar, Autism)			Floaters, Flashes of Light		
Cardiac (HTN, Stroke, Heart Disease, Vascular Disease, CHF)			Headaches		
Respiratory (Asthma, Bronchitis, emphysema, COPD, Sleep apnea)			Red Eyes		
Gastrointestinal/urinary (Chron's, Colitis, Ulcer, GERD, Celiac, Kidney disease, Prostate cancer, STD, BPH)			Light Sensitive		
Musculoskeletal (Arthritis, Fibromyalgia, Muscular Dystrophy, Ankylosing Spondylitis, Osteoporosis, Gout)			Eye Pain		
Skin / Integumentary (Eczema, Rosacea, Cold Sores, Shingles)			Waviness in Vision		
Endocrine (Diabetes I/II, Thryroid disease, Hormone dysfunction)			Loss of Peripheral Vision		
Blood / Lymph (anemia, Excess blood loss, hypercholesterol)			Loss of Color Vision		
Allergy / Immune (Frequent illness, allergy symptoms)					

List any Medications you take (including OTC medications, supplements, and vitamins):

_____

Do you have any allergies (drug or seasonal)? ☐Yes ☐ No If yes, explain:

_____

Health History: Please indicate below if you (S) or a family member **(M = mother, F = father, Sis = sister, B = Brother)** has any of the following;

Macular Degeneration (S / M, F, Sis, B)	Cancer (S / M, F, Sis, B)	Hyperthyroidism (S / M, F, Sis, B)
Cataracts (S / M, F, Sis, B)	Diabetes Type 1 (S / M, F, Sis, B)	Hypertension (S / M, F, Sis, B)
Glaucoma (S / M, F, Sis, B)	Diabetes Type 2 (S / M, F, Sis, B)	Hypothyroidism (S / M, F, Sis, B)

List any eye conditions or injuries you have ever had: _____

Do you: Smoke? ☐Yes ☐No If yes, how much? _____

Drink Alcohol? ☐Yes ☐No If yes, how much? _____

Do you currently wear glasses? ☐Yes ☐ No

Do you wear contact lenses? ☐Yes ☐ No

Are you pregnant or Nursing? ☐ Yes ☐ No

HIPAA Privacy Policy

Under the "Health Insurance Portability and Accountability Act" you have certain rights to privacy regarding your protected health information. You are free to refer to the Notice of Privacy Practices before you sign this form. As described in the Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and service provided here but also disclosures of your health information as may be necessary or appropriate for you to receive follow up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination, of benefits and payments; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment practices change.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You have the right to ask us to restrict the uses or disclosers made for purposes of treatment, payment, or healthcare operations, but as described in our Notice of Privacy Practices, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding to us. Our Notice of Privacy Practices describes how to ask for a restriction.

Initial:_____

Contact Lens Policy

Successful contact lens wear requires careful inspection of your contacts as well as an evaluation of the fit, prescription, and any follow-ups within a 90-day period. To ensure proper eye health and performance, additional testing and evaluation are necessary and an additional annual fee starting at $80 will be applied to your normal eye exam. Exact fees are based on case complexity. For contact lens patients who will be using their vision insurance, we are obligated to follow your insurance contracted billing rate for the contact lens fit and evaluation.

Initial:_____

Statement of Financial Policy

This includes co-pays, deductibles, and anything else that is not covered by insurance. While it is your responsibility, we will prepare any necessary forms to help you obtain your benefits from your insurance company. I understand that I am responsible for any amounts not paid by my insurance company. I do hereby and agree that if my account becomes delinquent and require the services of a collection agency or an attorney, I will pay reasonable collection fees, attorney fees, and all court costs for said collection.

As part of our recall program Franklin Vision Center would like to contact you via phone, email, and standard mail. If you authorize the disclosure of your name, address, telephone number, and next appointment date to Franklin Vision Center please sign below.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have either received or have access to the Notice of Privacy Practices from Franklin Vision Center. I have read and understand the recall program and Financial Policy.

Patient signature or Responsible Party:_____ Date: _____