PATIENT HISTORY QUESTIONNAIRE - NEW PATIENT

Name: Last _____ First _____ Middle _____ Prefers to be called: _____
Address _____ City_____ State_____Zip_____
Phone (Home) _____(Cell)_____texting ok ☐ (Work)_____
Email _____
Preferred method of contact: ☐Email, ☐Phone call, ☐Texting Date of Birth _____Age _____
Social Sec. # _____Employer_____
Male / Female_____Race/Ethnicity_____Height_____Weight_____
Vision insurance? Yes / No _____Medical insurance? Yes / No _____
Who is financially responsible for patient? ☐ Self ☐Other (Please print)_____
Relationship: _____ Date of Birth _____

MEDICAL INFORMATION

Do you have any of these medical problems?

High blood pressure Yes / No Diabetes Yes / No -- Approx. Year Diagnosed _____
High Cholesterol Yes / No Cancer Yes / No -- Type _____ Resolved: Yes / No

Do you have problems with any of these systems? (please circle all that apply)

Allergic/Immune	Yes / No	Gastrointestinal	Yes / No	Neurological	Yes / No
Cardiovascular(heart)	Yes / No	Genitourinary	Yes / No	Musculoskeletal	Yes / No
Fever/ Weight Loss	Yes / No	Blood/lymph	Yes / No	Psychiatric/ Mental	Yes / No
Endocrine(thyroid)	Yes / No	Integumentary(skin)	Yes / No	Respiratory(lung)	Yes / No
Ears/Nose/Throat	Yes / No	Other medical problems?_____			

Please answer all that apply: Your pharmacy's name & location:_____
Please provide a list **OR** list medications:_____
_____
_____
Are you allergic to any medications? Yes / No _____
Do you use cigarettes/tobacco? _____ Alcohol? _____ Other? _____
Name of medical doctor _____
Name of doctor's office _____
Are you pregnant/nursing? Yes / No

FAMILY HISTORY

(Father, Mother, Grandparent, Siblings)

Macular degeneration? Yes / No (relation)_____ Diabetes? Yes / No (relation)_____
Glaucoma? Yes / No (relation) _____ High blood pressure? Yes / No (relation)_____
Retinal detachment? Yes / No (relation)_____ Cataracts? Yes / No (relation)_____
Other? _____

PERSONAL HISTORY

Do you wear corrective lenses? Yes / No Glasses Contact lenses: Brand_____
What is the reason for today's visit? _____

Do you have any of the following? (please circle all that apply)

Glaucoma? Yes / No Cataracts? Yes / No Dry Eyes? Yes / No Eye pain? Yes / No
Floaters? Yes / No Flashing lights? Yes / No Double vision? Yes / No
Have you had any eye operations? Yes / No Type _____ Date _____
Have you had any eye injury? Yes / No Kind _____ Date _____
Headaches? Yes / No please describe _____
Other eye problems? _____

Whom may we thank for referring you? _____ relation?_____

Please turn over to complete, Thank you

Patient Signatures on File

There are two types of insurance that will help pay for eye care services and products. You may have both and our practice accepts both:

1. Vision care plans (such as Eyemed and VSP)
   Contact Lens Evaluations are not covered in a routine eye exam and will have an additional charge.
2. Medical insurance (such as Blue Cross and Medicare)
   * Vision care plan benefits are for routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.
   * Medical insurance must be used if you have any eye health or systemic health problems that affect the eyes. Your doctor will determine if these conditions apply to you, but some are determined by your history.
   * If you have both types of insurance plans, it may be necessary to bill some services to one plan and other sevices to the other. We will use coordination of benefits to minimize your out of pocket expenses.

As a courtesy, we verify your benefits and eligibility with your insurance company. Your coverage will be determined by your insurance company after the claim has been filed. We will file only insurance presented on the day of your appointment. All bills must be paid on the day of service.

Please read and sign below. I authorize the release of any medical information necessary to process my insurance. I also authorize payment of medical benefits from my insurance to Nice Eye Care for services rendered and I agree to pay all costs that my insurance does not cover.

Signature _____

We now offer a secure patient portal with information about your eye health using your email address. It allows you to update your health and contact information as well as to receive reports and prescriptions from your examination.

Please read and sign below. I agree to receive my eyewear and contact lens prescriptions through the patient portal.

Signature _____ Date _____

Please read and sign below if the patient is a minor. As legal guardian, I authorize Nice Eye Care and staff to provide any nessesary eye care in the examination and treatment of this patient.

Signature _____ Date _____

Relation to patient: _____

Thank you for assisting us by completing this form.
We appreciate you visiting us today and look forward to serving you .

Please present your insurance card to assist us in filing for your vision and medical benefits.