RIVERFRONT EYECARE

PATIENT HISTORY QUESTIONNAIRE

Last Name________________________ First Name_________________________ MI_____ Date______________

Home Address____________________________________ City_____________________ State_____ Zip________

Birth date__________ Sex_______ Social Security Number_______________________ Marital Status__________

Email__________________________Employer/School_____________________ Occupation_________________

Home_____________________ Cell____________________ Work__________________ Preference?__________

Name of Parent, Legal Guardian or Spouse___________________________________

Name of other family members whom we have provided care____

Vision and Medical Insurance Company_________________________ ID#__________________________

Subscriber Name_____________________ Subscriber birth date_________ Relationship to Patient_____________

Race (Optional): Please circle

American Indian or Alaskan Native   Asian   African American or Black   Native Hawaiian or other Pacific Islander

Caucasian or White   **Ethnicity (Optional):** Hispanic or Latino   Not Hispanic or Latino

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Medical History / Review of Systems:

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

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Are you allergic to any medications: YES NO Please list:____

Primary Care Physician:_______________________________ Pediatrician:_________________________________

Preferred Pharmacy:________________________ Location:____________________ Phone:___________________

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

- ○ Asthma
- ○ Diabetes
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ Thyroid Problems
- ○ Arthritis
- ○ Chronic Fever
- ○ Ear/Nose/Throat
- ○ Endocrine Problems
- ○ Pregnant/Nursing
- ○ AIDS
- ○ Gastrointestinal Problems
- ○ Heart Problems
- ○ Musculoskeletal Problems
- ○ Neurological
- ○ Depression/Anxiety
- ○ Respiratory Problems
- ○ Seasonal Allergies
- ○ Skin Problems
- ○ Urinary Problems
- ○ Hepatitis

Other conditions or 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
- ○ Flashers
- ○ Floaters
- ○ Glaucoma
- ○ Lazy/Crossed Eye
- ○ Loss of Vision
- ○ Macular Degeneration
- ○ Migraine/Headache
- ○ Retinal Detachment

Are you interested in correcting your vision with LASIK Surgery?____

Family History: (Mother, Father, Siblings, Grandparents)

- ○ Blindness
- ○ Cataracts
- ○ Glaucoma
- ○ Lazy/Crossed Eye
- ○ Macular Degeneration
- ○ Retinal Detachment
- ○ Diabetes
- ○ High Blood Pressure
- ○ Other Eye Disease or Condition:________________
  ____
  ____

Do you drive? Y/N If yes, do you have visual difficulty when driving? Y/N

If yes, please describe ____

Smoking and Alcohol History

- ○ Current every day smoker
- ○ Current some day smoker
- ○ Former smoker
- ○ Never smoker

Do you drink Alcohol? Y/N __________________________________

Do you use illegal drugs? Y/N __________________________________

If patient is 18 or under, please complete:

Any prenatal, perinatal or postnatal problems? Y/N ____

Any developmental problems? Y/N ____

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

Last eye care provider:____ Date of last exam:__________________

Are you currently having eye or vision problems? Y/N If yes, please explain:

____

Do you wear glasses? Y/N How old are they?_______

Have you ever worn contact lenses? Y/N If yes, when were they prescribed?______________________________

Do you wear contact lenses now? Y/N If not, why did you quit? ____

Are you interested in wearing contact lenses? Y/N If yes, please read the following regarding contact lenses:

Riverfront Eyecare prescribes quality contact lenses to improve your vision and 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 and eye exam to minimize the risk of serious eye problems. This additional testing is only done for contact wearers, not for patients who do not wear contact lenses. For this reason, there are additional contact lens evaluation and service 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 90 days.

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. PAYMENT IN FULL IS REQUIRED AT TIME OF SERVICE.**
- ○ **I agree to pay all co-pays, deductibles, co-insurances and non-covered services as determined by my insurance company.**
- ○ **I understand that there is a returned check fee applied to every returned check.**
- ○ **I authorize the release of medical information regarding my illness and treatment by Riverfront Eyecare to my insurance company.**
- ○ **I also authorize the release of my personal medical information to any doctor to whom I may be referred.**
- ○ **I understand that verification of eligibility is not a guarantee of payment as stated by my insurance company.**
- ○ **I authorize payment of my insurance benefits to Riverfront Eyecare.**
- ○ **We will file all insurance forms if Riverfront Eyecare is a participating provider for your plan.**
- ○ **We will supply to you an itemized statement which you may submit to your insurance carrier.**

______________________________________ SIGNATURE OF PATIENT OR LEGAL GUARDIAN

__________________________ TODAY'S DATE

RIVERFRONT EYECARE

HIPPA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose health information about you. The notice contains a Patient's Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about your for treatment, payment or other health care options. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made based on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information but the practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- This practice may condition receipt of treatment upon the execution of this consent.

Patient or Representative Signature:________________________________ Date:________________________

Printed Name:____