

# Patient Health History Form

Today's Date \_\_\_\_\_ D.O.B \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_  
Last First F M

ss# \_\_\_\_\_ Email \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work# \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Name of Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Please list in order of importance the present health concerns or symptoms you are having

Do you wear glasses? Yes ☐ No ☐ Contacts? Yes ☐ No ☐ Prescription Sunglasses? Yes ☐ No ☐

***Please indicate whether you have had any of the listed problems with your eyes within the past year.***

Blurred Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>	Loss of Peripheral Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>
Poor vision at night	Yes <input type="checkbox"/> No <input type="checkbox"/>	Double Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>
Temporary loss of vision	Yes <input type="checkbox"/> No <input type="checkbox"/>	Spots before your eyes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Flashes of lights	Yes <input type="checkbox"/> No <input type="checkbox"/>	Itching	Yes <input type="checkbox"/> No <input type="checkbox"/>
Burning	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pus like discharge	Yes <input type="checkbox"/> No <input type="checkbox"/>
Watery Discharges	Yes <input type="checkbox"/> No <input type="checkbox"/>	Gritty/Sandy feeling	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pain in eyes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Eyelids red or swollen	Yes <input type="checkbox"/> No <input type="checkbox"/>
Eyes Red or Bloodshot	Yes <input type="checkbox"/> No <input type="checkbox"/>	Loss of eyelashes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Temporary loss of vision	Yes <input type="checkbox"/> No <input type="checkbox"/>	Spots before your eyes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sensitive to light	Yes <input type="checkbox"/> No <input type="checkbox"/>	Eye Surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>
Eye injuries	Yes <input type="checkbox"/> No <input type="checkbox"/>		

**Are you currently being treated for any of the following conditions?**

Recent weight gain/loss	Yes <input type="checkbox"/> No <input type="checkbox"/>	Ear, Nose, Mouth, Throat	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Lung (I.e. Asthma/ COPD)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Kidney	Yes <input type="checkbox"/> No <input type="checkbox"/>	Venereal disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Gastrointestinal	Yes <input type="checkbox"/> No <input type="checkbox"/>	Musculoskeletal (I.e. Arthritis, M.S.)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Skin Disorders	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	AIDS or HIV+	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>
Neurologic	Yes <input type="checkbox"/> No <input type="checkbox"/>	Headaches/Migraines	Yes <input type="checkbox"/> No <input type="checkbox"/>
Lymph disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cataracts	Yes <input type="checkbox"/> No <input type="checkbox"/>	Macular Degeneration	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Please turn to back page.....**

## Patient Health History Form

Has any blood relative (Parents, Grandparents, Brothers, Sisters or Children) had  
Any of the following conditions

Condition	Yes	No	Relationship
Diabetes			
High Blood Pressure			
Cancer			
Cataracts			
Thyroid			
Heart Condition			
Glaucoma			
Macular Degeneration			

Please list ALL medication you are taking including non-prescription drugs:

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Please list any allergies to dyes, anesthetics or medications:

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Please list any surgeries, serious accidents, or head injuries:

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When was your last eye examination: \_\_\_\_\_ By Dr. \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

A contact lens evaluation often is NOT a covered benefit under insurance plans.  
Therefore, the fee for the evaluation will be collected the day of the appointment. If  
you have any questions about your coverage, please ask our staff.

I accept a contact lens evaluation Yes ☐ No ☐

I understand that if I decline a contact lens evaluation I will not receive a contact lens  
Prescription. Initial here : \_\_\_\_\_

### Acknowledgement of Receipt

I acknowledge that I have reviewed the posted copy Irving Edelsberg's notice of privacy practices.  
Copies of the notice are available upon request.

Patient Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

## Financial Policy

We are pleased that you have chosen Optometric Associates for your healthcare needs. It is our goal to provide you with the highest quality healthcare services possible. In choosing our services you have accepted the financial responsibility to ensure full payment for our services.

### Our Policy Regarding:

**Co-payment:** Your co-payment as stated by your insurance company will be collected from you the day of your visit. You may make your payment either by cash or credit card. We gladly accept Visa, MasterCard, American Express and Discover cards for payment.

**Medicare:** We are a participating provider for Medicare. If you do not have a Secondary Insurance you will be responsible for the 20% coinsurance due the day of your appointment. If you are having a prescription the fee for this service is **\$30.00** due the day of your appointment. This fee is due regardless if you have a secondary insurance plan or not.

**HMO/PPO/POS:** Our office participates with most HMO, PPO and POS plans. You are responsible at the time of service for any co-payment stated on your insurance card. Any additional amounts due by you will be billed to you once your insurance processes the bill.

**Major Medical:** Your major medical insurance coverage is a contract between you and your insurer. As a courtesy to you, Optometric Associates will bill your insurance carriers directly. You are responsible for any deductible and co-payment or coinsurance that is determined by your insurance carrier.

**Contact Lens Evaluations:** Most insurance plans do not cover this service. In order for the doctor to generate a contact lens [prescription, you must have the evaluation due annually. If you aren't sure if your insurance will cover this service, ask our staff.

**Eyeglasses Purchased Elsewhere:** There will be a **\$50** charge for verification of prescription accuracy. Any issues with eyeglasses after **30 days** requires an office visit.

**Cancellation Policy:** If you fail to call and cancel your appointment, you will be billed a cancellation fee of \$25.00 which your insurance company will not pay.

I have read the above policy regarding my financial responsibility to Optometric Associates for providing medical care to me or the below named patient. I understand that my failure to comply with the financial policies of Optometric Associates may cause interruptions in my medical care. I understand that it is my responsibility to inform this office of any correspondence that I receive from my insurance company notifying me of a change or cessation of my insurance coverage.

Patient name (print) \_\_\_\_\_

Responsible Party Signature: \_\_\_\_\_ Date \_\_\_\_\_