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

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

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

Please turn to back page…

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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:

Please list any allergies to dyes, anesthetics or medications:

_____

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

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 of 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%o 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: FRAMES PURCHASED ELSEWHERE WILL NOT BE ADJUSTED OR REPAIRED. If you are having difficulty seeing through your new glasses, there will be an $89 charge for us to verify whether or not the lenses were made as prescribed.

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_____

Revised: 5/12/2021