

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)

Respiratory(lung) Yes / No Gastrointestinal Yes / No Integumentary(skin) Yes / No
Cardiovascular(heart) Yes / No Nervous Yes / No Mental Yes / No
Ears/Nose/Throat Yes / No Genitourinary Yes / No Endocrine(thyroid) Yes / No
Blood/lymph Yes / No Musculoskeletal 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? Yes / No

FAMILY HISTORY

(Father, Mother, Grandparent, Siblings)

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

PERSONAL HISTORY

Do you wear corrective lenses? Yes / No Glasses Contact lenses
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)
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 services 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 necessary 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.