

new patient history questionnaire

Thank you for choosing Brevier Optical for your vision care. In order to provide you with the best care possible, we ask that you answer the questions below. If you prefer, we will be happy to sit down with you to help you complete this form.

Name: _____ Date: _____
(First) (M.I.) (Last)

I prefer to be called: _____ Date of Birth: _____ Age: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (c): (_____) _____ Phone (h): (_____) _____ Phone (w): (_____) _____

Emergency contact: _____ Relationship: _____ Phone: _____

E-mail: _____ Please check if you do NOT wish to receive eye care updates

How did you find us? insurance/provider list drive/walk by friend/family _____ other _____

Payment is due at the time of service. Payment will be made via: cash check charge insurance _____

REQUIRED INSURANCE INFORMATION:

EMPLOYMENT STATUS: full-time part-time not employed student, full-time student, part-time active duty, military

IF YOUR INSURANCE POLICY IS NOT IN YOUR NAME, PLEASE PROVIDE THE FOLLOWING:

POLICYHOLDER'S NAME: _____ POLICYHOLDER'S DATE OF BIRTH: ____/____/____

POLICYHOLDER'S ADDRESS: same as above OR fill out below:

Address: _____ City: _____ State: _____ Zip: _____

PATIENT MEDICAL INFORMATION

Many systemic health conditions, as well as medications, can have an impact on the health of your eyes. Please complete the following information so your doctor can provide you with the most thorough care and evaluation of your eye health.

Have you had any ongoing problems with any of the following systems? Please check (v) all that apply:

_____ gastrointestinal	_____ nervous system	_____ endocrine/glands
_____ ears/nose/throat	_____ urinary tract	_____ blood/lymph
_____ cardiovascular/heart disease	_____ muscles/bones	_____ allergic/immunologic
_____ respiratory	_____ integument/skin	_____ headaches
_____ high blood pressure	_____ cancer	_____ psychiatric/psychological
_____ diabetes (if yes, date of diagnosis: _____)	<input type="checkbox"/> Type I <input type="checkbox"/> Type II	

Please explain: _____

Other health problems: _____

Are you currently taking medication? y n If yes, please list: _____

Are you allergic to medication? y n Please list: _____ Do you use cigarettes/tobacco? y n

Name of primary care physician: _____ Date of last visit: _____

* CONTINUED ON OTHER SIDE *

PATIENT'S EYE HISTORY

Date of last eye exam _____ By whom? _____ Dilated? y n

Do you wear glasses? y n Do you wear contact lenses? y n If yes, soft rigid gas permeable/hard disposable

Please check any of the following conditions you have/had:

_____ glaucoma _____ retinal detachment _____ dry eyes _____ cataracts _____ macular degeneration

Do you have any other eye conditions or problems? If so, describe _____

Have you had a serious eye injury or eye surgery? If yes, please describe _____
_____ date?: _____

Are you using any eye drops (prescription or over-the-counter)? Please list: _____

Please describe any problems with your eyes for which you are seeking treatment today: _____

Check all that apply: itchy eyes stinging/burning flashes/floaters eyestrain/eye fatigue blurry vision red eyes

Are you planning to purchase new glasses today? yes no

Are you considering LASIK / refractive surgery? yes, I'd like to discuss it no

FAMILY EYE & MEDICAL HISTORY

Please check (v) any conditions that have occurred in your immediate family:

_____ glaucoma	relation _____	_____ cataracts	relation _____
_____ macular degeneration	relation _____	_____ diabetes	relation _____
_____ retinal detachment	relation _____	_____ high blood pressure	relation _____

In order to assist us in processing your insurance claim and to allow for communication with your other health care providers, please read and sign the following:

I authorize Brevier Optical to bill my insurance carrier on my behalf. I request that payment of authorized insurance benefits be made to this clinic for any services furnished me by this doctor/clinic. I understand that I am financially responsible for any balance not covered by my insurance carrier, and that a quotation of benefits is not a guarantee of coverage. A copy of this signature is valid as the original. I authorize any holder of medical information about me to release to my medical insurance carrier any information needed to determine the benefits payable for related services for myself and/or my dependents.

Patient/guardian: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I authorize the release of medical information regarding myself/my dependents and my current condition to my referring, consulting, or treating physicians.

Patient/guardian: _____

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT:

We keep a record of the health care services we provide to you. You may request a copy of your medical record in writing. We will not disclose your record to others unless you direct us to do so or unless legal authorities authorize or compel us to do so. You may request a copy of your medical record or get more information by contacting the Brevier Optical Privacy Officer. Our Notice of Privacy Practices is available at the reception desk and is posted in the clinic. The Notice describes in greater detail how your health information may be used or disclosed, and how you can access your information. You are entitled to a copy of this Notice and it is available at your request.

I acknowledge the Notice of Privacy Practices has been offered to me and is readily available in accordance with the Health Insurance Portability and Accountability Act.

Patient/guardian: _____

FOR DOCTOR'S USE ONLY: This form was reviewed by _____ date: _____