Today's Date:_____

Medical History Questionnaire

Name: Mr. Mrs. Miss. Ms. Dr.

First:_____Middle_____

Last_____

DOB:_____ Age____ Sex: M F

Address:_____

City:_____Zip:_____

Employer:_____

Occupation:_____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced

Cell Phone:_____

Home Phone:_____

Work Phone:_____

Email:_____

Last Eye Exam:_____

Doctor:_____

Last Primary Visit: _____

Doctor:_____

How did you hear about us?

_____

List any Medications you are currently taking:

_____

_____

_____

Are you allergic to any medications ☐ Yes ☐ No
If yes, please list:

_____

What is the purpose of Today's Visit?

Eye Exam for glasses ☐ Yes ☐ No
Contact Lens Evaluation ☐ Yes ☐ No
If yes, have you worn Contacts before?
☐ Yes ☐ No
Medical Visit ☐ Yes ☐ No
Other:_____

Patient/Responsible Party (If under 18)

Full Name:_____

Last four of Social Security #: _____

(ONLY required when filling insurance)

Minors will not receive treatment without a parent or guardian present. Prearrangements must be made with our office if another party will be bringing the child for their appointment. ***The parent or guardian accompanying a minor is responsible for co-insurance or full payment at time of service.*** *In case of divorce, regardless of decree, the parent bringing the child in is responsible for payment.*

Social History

Are you pregnant or nursing? ☐ Yes ☐ No

Do you use cigarettes/tobacco? ☐ Yes ☐ No

Do you use Alcohol? ☐ Yes ☐ No

Other substances? ☐ Yes ☐ No

Race:

☐ American Indian or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander ☐ White

☐ Black or African American ☐Asian ☐ Other

Ethnicity:

☐ Hispanic/Latino ☐ Not Hispanic/Latino

Family History

Has anyone in your family been diagnosed with:

High Blood Pressure ☐ Relation: _____
Diabetes ☐ Relation: _____
Glaucoma ☐ Relation: _____
Retinal Detachment ☐ Relation: _____
Macular Degeneration ☐ Relation: _____
Other Eye Condition ☐ Relation: _____
Explain: _____

Patient Health History_Check Yes or NO_ if YES, explain.

Cardiovascular (heart)	☐ Yes	_____	☐ No
Gastrointestinal	☐ Yes	_____	☐ No
Psychiatric	☐ Yes	_____	☐ No
Musculoskeletal	☐ Yes	_____	☐ No
Endocrine (glands)	☐ Yes	_____	☐ No
Eyes	☐ Yes	_____	☐ No
Neurological	☐ Yes	_____	☐ No
Respiratory (lung)	☐ Yes	_____	☐ No
Integumentary (skin)	☐ Yes	_____	☐ No
Ear, Nose, Mouth &Throat	☐ Yes	_____	☐ No
Headaches	☐ Yes	_____	☐ No
Cholesterol	☐ Yes	_____	☐ No
Blood Pressure	☐ Yes	_____	☐ No
Diabetes	☐ Yes	_____	☐ No

Other major illnesses:_____

Patient Eye History

Are you CURRENTLY having problems with any of the following? **Check Yes or No**

Blur at Distance	☐ Yes	☐ No
Blur at Near	☐ Yes	☐ No
Dry Eyes	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Floaters in Vision	☐ Yes	☐ No
Redness	☐ Yes	☐ No
Itching	☐ Yes	☐ No
Mucous Discharge	☐ Yes	☐ No
Eye Pain	☐ Yes	☐ No
Flashes in Vision	☐ Yes	☐ No
Blindness	☐ Yes	☐ No

Other _____

Have you had any eye operations? ☐ Yes ☐ No

Have you had any eye injuries? ☐ Yes ☐ No

If yes, What type?_____Date_____

If your examination reveals a medical condition or disease related to your eye, then your visit is NOT COVERED by your vision plan. Unfortunately, the doctor cannot tell if medical eye conditions exist before you are thoroughly examined. At this point, your medical condition will become the priority and will be filed with your medical insurance. We will be happy to reschedule your routine exam after the medical condition has been resolved.

Insurance Information

Vision Insurance Please provide copy of card

_____ initial if none

Provider:_____

Member ID:_____

Relationship to card holder: _____

Insurance Holder Information (if other than Patient)

Full Name _____

DOB:_____ SS#_____

Health Insurance Please provide copy of card

_____ initial if none

Provider:_____

Member ID:_____

Relationship to card holder: _____

Insurance Holder Information (if other than Patient)

Full Name _____

DOB:_____ SS#_____

Other Insurance Please provide copy of card

_____ initial if none

Provider:_____

Member ID:_____

Relationship to card holder: _____

Insurance Holder Information (if other than Patient)

Full Name _____

DOB:_____ SS#_____

Our Insurance Filing Policy

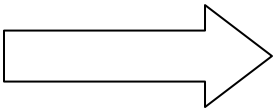
If we are filing insurance for today's visits we are doing so as a courtesy to our patient- it is your responsibility to provide us with current and proper insurance information before or at the time of your appointment. If you fail to provide us with this information you agree to pay for all charges in full and to file for your benefits on your own. We are happy to provide any required documentation, but Triangle EyeCare, OD PA (TEC) will not file your insurance for you unless it is received before your appointment.

Please understand that insurance policies are a contract between the policy holder and the insurance company. Our office is not a part of that contract. Every effort will be made to closely estimate your co-payments and deductibles. We at no time guarantee what your insurance will or will not pay on each claim. We will cooperate fully with the regulations and requests of your insurance company that may assist in accurately filing your claim. Disputes or denied claims should be directed to your insurance carrier and/or employer. If your insurance company has not made payment within 30 days, we will ask you to contact your insurance company to make sure payment is expected. If payment is not received within 90 days from the date of filing, or your claim is denied, you will be responsible for paying the full amount.

Authorization for Assignment of Benefits

I understand that not all services are a covered benefit in all contracts. Therefore, if for any reason my insurance company denies all or partial benefits, I am liable for the entire unpaid balance. I understand the doctor is acting in good faith by agreeing to perform said services prior to payment and this acts as my guarantee to pay the practice, in full, for all services rendered. I authorize TEC to release any information needed to process my insurance claim. I also authorize my insurance benefits to be paid directly to TEC on my behalf.

Patient/Guardian Signature *Date*



ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE

The law requires that Triangle EyeCare OD PA (TEC) make every effort to inform you of your rights related to your personal health information. By signing below, I acknowledge that (**CHECK ONE**):

☐ I have read or had explained to me TEC's Notice of Privacy Practice and agree to continue my care with TEC under said terms.

☐ I was given the opportunity to read TEC's Notice of Privacy Practices and declined but wish to continue my care with TEC under the terms of TEC's privacy policy.

☐ I have read or had explained to me TEC's notice of Privacy Practice and do not wish to continue my care with TEC under said terms.

☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as:

_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY**.**

If you are signing as a personal representative or guardian of the patient, please indicate your relationship: _____

Patient/Representative Signature **Date**

_____

Another Tool for Preserving Eye Health

A new, highly sophisticated computerized instrument now allows us to take high quality digital images of the retina and other structures inside your eye. This procedure assists Dr. Klaus in early detection of many disorders, including glaucoma, diabetic retinopathy, macular degeneration, retinal detachments and many other vision threatening conditions. The images are stored in our computer and can be compared with images in the future, allowing us to observe even the smallest amount of change.

We strongly recommend that all patients have this procedure performed and it is especially important for people who have:

1. Headaches
2. See spots or flashes
3. Family history of diabetes
4. Family history of glaucoma
5. High blood pressure
6. High cholesterol
7. Reached the age of 40
8. Sudden vision change
9. Your vision is not correctable to 20/20
10. Never had the procedure previously
11. Have had retinal disorders such as a detachment, tear or floaters
12. Would like a "baseline" image for future comparisons

Screening retinal photography is a NECESSARY part of your eye exam if you fall into any of the above categories. If pathology or a risky condition is documented with these photos, or more are needed, this "photographic study" can be billed to your insurance as part of your treatment plan. **There is an additional charge of <u>$29.00</u> for this screening procedure and it is not covered by insurance** if the screening does not detect any unusual condition.

Please initial the appropriate line below and sign at the bottom.

_____ **I DO** want the procedure ($29.00 Fee)

_____ **I DO NOT** want the procedure