PRAIRIELAND EYE CLINIC

Today's Date_____/_____/_____

Referred By _____

Spouse_____

Name_____ Responsible Party_____

Address_____ Medical Doctor_____

_____ Specialists_____

City_____ Date/Place of Last Exam_____/_____/_____

State_____ Zip_____ _____

Phone_____ Date of Last Medical exam_____/_____/_____

Cell Phone_____ Emergency Contact_____

Email_____ Emergency Phone_____

DateofBirth_____/_____/_____ Hobbies/Interests_____

Social Security #_____/_____/_____ _____

Occupation_____ **Preferred Language**

Employer _____ English Spanish Other_____

Work Phone_____ **Ethnicity (circle one)**

Race (circle one) ☐Hispanic or Latino ☐Not Hispanic or Latino

☐White ☐Black/African American ☐Asian **Insurance** (please bring your insurance card to your appointment)

☐Native Hawaiian/Other Pacific Islander Primary_____

☐American Indian/Alaskan Native Secondary_____

MEDICAL HISTORY QUESTIONNAIRE - PERSONAL MEDICAL HISTORY

Do you have any allergies to medications? ☐No ☐Yes (list)_____

List any medications and reason. (Include oral contraceptives, aspirin, over the counter medications and home remedies.)

_____

_____

List all major illnesses/health conditions. _____

_____

List all major injuries, surgeries and/or hospitalizations you've had. _____

_____

MEDICAL HISTORY QUESTIONNAIRE - PERSONAL MEDICAL HISTORY

Check any of the following that you have had: ☐ Lazy Eye ☐ Eye Injury ☐ Glaucoma ☐ Cataracts ☐ Retinal Disease ☐ Surgery to Your Eye(s) - please describe_____

CHECK ALL THAT APPLY

Do you smoke? ☐ No ☐ Yes Amount_____
Have you ever smoked? ☐ No ☐ Yes
Do you consume alcohol? ☐ No ☐ Yes Amount_____
Are you pregnant and/or nursing? ☐ No ☐ Yes Due Date_____

Do you wear glasses? ☐ No ☐ Yes How old are your present pair of lenses? _____ Frame?_____
Do you use a computer ☐ No ☐ Yes Hours per day? _____ Distance from computer? _____
Do you experience problems with glare? ☐ No ☐ Yes
Do you experience problems with night vision? ☐ No ☐ Yes
Do you experience visual difficulty when driving? ☐ No ☐ Yes
Do you wear prescription sunglasses? ☐ No ☐ Yes

Do you wear contact lenses? ☐ No ☐ Yes
If not a contact lens wearer, are you interested in trying contact lenses at this time? ☐ No ☐ Yes
Type of contact that you wear: ☐ Soft ☐ Rigid ☐ Extended Wear Brand_____
Are you satisfied with your current contact lenses? ☐ No ☐ Yes
Comments_____

FAMILY HISTORY (parents, grandparents -signify maternal or paternal, siblings, children; living or deceased)

Blindness	☐ No	☐ Yes	☐ Possibly	Relationship _____
Cataract	☐ No	☐ Yes	☐ Possibly	Relationship _____
Crossed Eyes	☐ No	☐ Yes	☐ Possibly	Relationship _____
Glaucoma	☐ No	☐ Yes	☐ Possibly	Relationship _____
Macular Degeneration	☐ No	☐ Yes	☐ Possibly	Relationship _____
Retinal Detachment/Disease	☐ No	☐ Yes	☐ Possibly	Relationship _____
Arthritis	☐ No	☐ Yes	☐ Possibly	Relationship _____
Cancer	☐ No	☐ Yes	☐ Possibly	Relationship _____
Diabetes	☐ No	☐ Yes	☐ Possibly	Relationship _____
Heart Disease	☐ No	☐ Yes	☐ Possibly	Relationship _____
High Blood Pressure	☐ No	☐ Yes	☐ Possibly	Relationship _____
Kidney Disease	☐ No	☐ Yes	☐ Possibly	Relationship _____
Lupus	☐ No	☐ Yes	☐ Possibly	Relationship _____
Thyroid Disease	☐ No	☐ Yes	☐ Possibly	Relationship _____
Other_____	☐ No	☐ Yes	☐ Possibly	Relationship _____

HIPPA NOTIFICATION

I acknowledge that I have had an opportunity to review/receive a copy of the Privacy Practices at Prairieland Eye Clinic.

RESPONSIBILITY OF PAYMENT

I understand that my insurance provider may not cover some or all of the services or products I am receiving today. Although Prairieland Eye Clinic may provide the service of billing my insurance, it is not a guarantee of payment. I understand that my coverage is a contract between my insurance company and myself. I have decided to receive the services and/or materials that are being submitted to my insurance and agree to be financially responsible for any uncovered expenses. I authorize the use of this form on all of my insurance submissions and release information. I understand that I am responsible for my bill. I authorize direct payment to my doctor.

Signature_____ Date_____

Email Form