Medical History Questionnaire

Name:_____

Birth date: _____ Date: _____

Please circle Yes (Y) or No (N) to the following questions:

Have you been diagnosed with any of the following:			
Y	N	Hypertension	
Y	N	High cholesterol	
Y	N	Heart Disease	
Y	N	Cancer	
Y	N	Pre-diabetes	When were you diagnosed:
Y	N	Diabetes	List most recent A1c: Average blood sugar:
Y	N	Thyroid Disorder	
Y	N	Sexually Transmitted Disease	
Y	N	Headaches	

Please list any other medical conditions: _____

Have you been diagnosed with any of the following eye conditions: **If yes, in the space provided please write in when and where**		
Y	N	Diabetic Retinopathy
Y	N	Cataracts
Y	N	Macular Degeneration
Y	N	Dry eye
Y	N	Retinal detachment
Y	N	Glaucoma
Y	N	Strabismus (eye turn)
Y	N	Amblyopia (lazy eye)
Y	N	Keratoconus
Y	N	Iritis

Have you ever had any of the following ocular surgeries or treatments: **If yes, in the space provided please write in when and where**		
Y	N	LASIK
Y	N	PRK
Y	N	Avastin or Lucentis injection
Y	N	Retinal laser treatment
Y	N	Cataract surgery
Y	N	Patching therapy
Y	N	Vision Therapy

Please list any other eye problems, treatments or injuries:_____

_____

Do you take any medications or supplements? Yes No

If yes, list all prescription and over the counter medications and with the dosage: _____

_____

Are you allergic to any medication? Yes No

If yes, please list:_____

_____

Do you use any eye drops? Yes No

If yes, please list:_____

_____

Do you suffer from any allergies? Yes No

If yes, please list:_____

_____

Are you currently pregnant? Yes No Are you currently nursing? Yes No

Do you have a family history of any of the following: **If yes, in the space provided please write whom in your family**		
Y	N	Glaucoma
Y	N	Macular degeneration
Y	N	Color blindness
Y	N	Vision loss
Y	N	Diabetes
Y	N	Heart disease
Y	N	Cancer
Y	N	Hypertension
Y	N	High cholesterol

Do you currently smoke? Yes No If Yes, _____packs per day _____how many years

Are you a former smoker? Yes No If yes, _____ years smoked _____ when did you quit

Do you consume alcohol? Please circle: None/ Daily/ Socially/Alcohol Dependent/ Above average

Do you use any recreational drugs? Yes No If yes, please list _____

Have you ever had a blood transfusion? Yes No If yes, when _____

Contacts:

Do you wear contact lenses? Yes No Are you interested in contacts? Yes No

If yes, please answer the following:

What brand of contacts do you wear?_____

Are you happy with your contacts? Yes No

How often do you throw your contacts away/change your contacts?_____

What contact solution do currently you use?_____

How many hours a day do you wear your contacts? _____

Do you ever sleep in your contacts? Yes No

Previous Eye Exam:

Date of last exam _____ Doctor/Clinic_____City _____

Primary doctor _____City _____Phone_____ Last Visit _____

Mill Creek Family EYE Center

Confidential Patient Information

Patient: (circle one) Mr. Mrs. Miss Ms. Dr. Other_____ Date: _____

_____ Birthdate: _____ Gender: M / F

First MI Last

Marital Status: Single / Married / Widowed / Divorced / Separated Social Security #:_____-_____-_____

Race: (Circle One) Caucasian / American Indian / Alaska Native / Native Hawaiian / Asian

East Indian / African American / Hispanic / Pacific Islander / Other

Home Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: Home: (____) _____ Work: (____) _____ Cell: (____) _____ Text Ok: Y / N

Email: _____Communication Preference (circle one): Email Phone Mail Text

Employer/School: _____ Occupation/Grade: _____

Person Responsible for Account: _____ Relationship: _____

Address & Phone (if different):_____

Insurance Information

Primary:

Vision Insurance: _____ID #:_____ Group #:_____

Medical Insurance: _____ ID #:_____ Group#: _____

Subscriber's Name: _____Relationship to Patient: _____

Subscriber's Birthdate_____ Subscriber's SS#____-____-____Subscriber's Employer: _____

Secondary:

Vision Insurance: _____ID #:_____ Group #:_____

Medical Insurance: _____ ID #:_____ Group#: _____

Subscriber's Name: _____Relationship to Patient: _____

Subscriber's Birthdate_____ Subscriber's SS#____-____-____Subscriber's Employer: _____

How did you hear about our office? (Circle one) Insurance List / Phone Book / Saw Sign / Personal Referral
Advertisement / Walk In / Internet / Word of Mouth / Employee Referral / Other

Who may we thank for referring you: _____

MILL CREEK FAMILY EYE CENTER

FINANCIAL POLICY

It is our goal to provide thorough, quality care to our patients at reasonable costs. To help reduce the cost of billing, the following policy has been adopted.

1. NO INSURANCE COVERAGE: Payment for all services provided is expected at the time services are rendered. All materials (eyeglasses, contacts, etc.) must be paid for in full before they can be taken from the office. Eyeglass lenses are custom made and cannot be refunded.

2. INSURANCE COVERAGE: As a courtesy, we will estimate your insurance coverage, however, health insurance is a personal contract between you and your insurance company, and thus you are responsible for knowing the limitations of your insurance contract as well as your eligibility for coverage. Should your insurance deny your claim or eligibility for coverage, you are responsible for all fees accrued in your behalf.

   _____
   Patient Initials

3. A. CONTRACT: Mill Creek Family Eye Center will bill and await payment for up to 60 days for covered services and materials by those insurance carriers for which our office is a contracted provider. After 60 days, the insurance balance becomes your responsibility. Co-pays and balances for services are expected at the time services are rendered. Balances on materials or non-covered items become your responsibility as outlined above for those with no insurance.

   B. NON-CONTRACT: Mill Creek Family Eye Center cannot await payment from non-contracted insurance carriers. We will gladly assist in the billing by providing an itemized statement for you to submit and await reimbursement. Payment for services and materials are your responsibility as outlined for those with no insurance coverage.

4. ACCOUNTS WITH OUTSTANDING BALANCES: You will receive a statement at the beginning of the month. The balance is due before the end of the month; if full payment has not been received by the end of the month, the account will be past due and a 1.5% finance charge (18% APR) will be added to the balance. Returned checks are subject to a $25.00 processing fee.

5. INITIATION OF COLLECTION PROCEEDINGS: This office will not carry balances for more than 90 days. All accounts that are 90 days past due will be referred for collection proceedings. In the event collection proceedings are initiated, you will be responsible for any and all collection fees, i.e., attorney fees, court costs, etc.

I have read, understand and agree to follow the Financial Policy of Mill Creek Family Eye Center. I understand that I am ultimately responsible for payment of the account. I authorize payment of insurance benefits to this office. I also authorize release of any medical records necessary to process any claims.

Signature of Responsible Party: _____Date: _____

Notice of Privacy Practices (Acknowledgment of Receipt): I acknowledge that I have reviewed a copy of the Notice of Privacy Practices of Mill Creek Family Eye Center effective date April 14, 2003. I have been made aware that a copy is available if I desire one for my own records.

Signature: _____ Patient Name: _____Date: _____

(You are entitled to a copy of this agreement. Please let the receptionist know if you would like a copy) *05/15*