# Medical History Questionnaire

**Patient Name:** ____________________ **Birth Date:** ________ **Date:** ________
Street Address: ____________________ City, St, Zip: ____________________
Home Phone: __________ Work Phone: __________ Cell Phone: __________
Employment Status: FT/PT/Self/Student/Retired/None Occupation: __________
Employer: ____________________ SSN: __________
Insurance Co.: ____________________ Group#: __________
Email: __________ Member ID#: __________ Member DOB: __________
Member Name (if other than patient name): __________ Referred by: __________
Member Employer: ____________________
Date of last eye exam: __________ Date of last medical exam: __________
Primary care physician: ____________________

Please list medications you take (including oral contraceptives, over the counter medications, vitamins & supplements):
____________________
____________________

Please list all known allergies to medicine, food or the environment: ____________________
____________________
____________________

Please describe any major illness, injury or surgery you have had since your last visit (if new patient, in last 5 years):
____________________
____________________
____________________

**✓ MEDICAL HISTORY: please note ONLY if YOU or a family member have been diagnosed or treated for:**

| Medical Condition | SELF | Family Member | Family Relationship to me (mother; sibling) |
|---|---|---|---|
| Arthritis | ❑ | ❑ | ________ |
| Blindness | ❑ | ❑ | ________ |
| Breathing Problems (Asthma/Emphysema) | ❑ | ❑ | ________ |
| Cancer | ❑ | ❑ | Type: ________ |
| Cataracts | ❑ | ❑ | ________ |
| Corneal Problems | ❑ | ❑ | ________ |
| Crossed, Lazy or Turned Eyes | ❑ | ❑ | ________ |
| Diabetes | ❑ | ❑ | ________ |
| Diabetic Retinopathy | ❑ | ❑ | ________ |
| Eye Injury / Surgery | ❑ | ❑ | ________ |
| Glaucoma | ❑ | ❑ | ________ |
| Heart Disease | ❑ | ❑ | ________ |
| High Blood Pressure | ❑ | ❑ | ________ |
| High Cholesterol | ❑ | ❑ | ________ |
| Kidney Disease | ❑ | ❑ | ________ |
| Keratoconus | ❑ | ❑ | ________ |
| Lupus | ❑ | ❑ | ________ |
| Macular Degeneration | ❑ | ❑ | ________ |
| Migraine Headache | ❑ | ❑ | ________ |
| Retinal Detachment | ❑ | ❑ | ________ |
| Retinal Disease | ❑ | ❑ | ________ |
| Stroke | ❑ | ❑ | ________ |
| Thyroid Disease | ❑ | ❑ | ________ |
| Vertigo / Inner Ear Disorder | ❑ | ❑ | ________ |
| Other Condition or Disease | ❑ | ❑ | ________ |

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☑ **Please CHECK ALL symptoms YOU have experienced within the past 30 days:**

- ☐ Insomnia / sleeplessness
- ☐ Dizziness / vertigo
- ☐ Fever
- ☐ Allergies / Hay fever
- ☐ Sinus congestion
- ☐ Runny nose
- ☐ Dry throat or mouth
- ☐ Chronic cough / Bronchitis
- ☐ Asthma / Emphysema
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures
- ☐ High blood sugar
- ☐ Low blood sugar
- ☐ Heart / chest pain
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Depression
- ☐ Anxiety
- ☐ Miscellaneous pain ______________________
- ☐ Intestinal problems
- ☐ Acid reflux
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas / bloating
- ☐ Kidney / bladder problems
- ☐ Rheumatoid Arthritis
- ☐ Muscle pain (neck/shoulders)
- ☐ Joint pain (neck/shoulders)
- ☐ Anemia
- ☐ Bleeding / bruising
- ☐ Weight gain
- ☐ Weight loss

## Social History

| | | |
|---|---|---|
| Do you use tobacco products? | ☐ no | ☐ yes |
| Do you drink alcohol? | ☐ no | ☐ yes |
| Do you use illegal drugs? | ☐ no | ☐ yes |

Are you currently taking or have previously taken Flomax (Tamsulosin) or Proscar (Finasteride) ☐ Yes ☐ No

| | | |
|---|---|---|
| **Do you currently wear glasses?** | ☐ Yes | ☐ No |
| Is your vision blurry with your current eyeglasses? | ☐ Yes | ☐ No |
| Are you having problems with visual tasks at work/school? | ☐ Yes | ☐ No |
| Have you ever worn or do you currently wear contacts? | ☐ Yes | ☐ No |
| If NO, are you interested in contact lens correction? | ☐ Yes | ☐ No |
| Are you interested in learning more about LASIK? | ☐ Yes | ☐ No |
| Are you interested in learning more about nearsightedness control and non-surgical vision correction with orthokeratology? (Available for patients ages 8 and up) | ☐ Yes | ☐ No |
| Are you interested in Botox/Lattise? | ☐ Yes | ☐ No |

**How old are they?** ___ yrs

**FOR INSURANCE PURPOSES**

Preferred Contact: Phone/email/Postal

Race: American Indian/Alaska Native Asian/African American or Black/Hispanic/Native Hawaiian or Other Pacific Island/White

Ethnicity: Hispanic or Latino
Native Hawaiian
Other Pacific Island
Not Hispanic or Latino

______________________________________________

______________________________________________

______________________________________________

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______________________________________________

# Thomas Eyecare & Optical, LLC
# Thomas Eyecare, LLC

3619 Park East Dr. Suite 306
Beachwood, OH 44122

### FINANCIAL POLICY

Thank you for choosing our office as your eye care provider. The following is a statement of our financial policy. Please read carefully prior to any services performed.

**NON-INSURED PATIENTS:**

We ask that all cash paying patients requiring only services pay in full all charges at the time of services rendered. When purchasing materials such as contact lenses, glasses, ect., we require a 50% deposit with the balance due upon delivery of those materials. All materials which can be ordered and delivered on the same day must be paid in full when ordered.

**INSURED PATIENTS:**

Your insurance policy is a contract between you and your insurance company. We will submit charges to your insurance company if we are a participating provider, and if you have given us all the required information. We must have the most current copy of your insurance information or card. You must notify us immediately of any change in your insurance coverage. Our receptionist will try to gather most of this information when she schedules or confirms your appointment via telephone. Please be aware that some, and perhaps all of the services provided may be considered "non-covered services" according to your policy or your eligibility. You will still be responsible for payment of these services. **If we are a non-participating provider with your insurance company you will be responsible for charges at the time of service.** We reserve the right to determine if your exam will be billed as a medical versus vision exam and how it will billed to your insurance accordingly. We will assist in completion of any forms you have available the day of the appointment.

**AUTHORIZATION AND REFERRALS:**

At the time of the office visit, you are responsible for all professional fees and materials if referral or authorization is not received. Please check with our receptionist for the current list of insurance companies with which we participate. At the time of service we will collect the co-payment indicated by your insurance. You will be responsible for payment of any deductibles, co-insurance or non-covered services.

**MINOR PATIENT (UNDER 18 YEARS)**

The parent/guardian/adult accompanying a minor child is responsible for full payment. Please check with your insurance carrier/policy to determine which company is the primary before the appointment. In divorce cases, the parent who brings the child in for services is the responsible party.

**PAYMENT OPTIONS:**

All co pays, refraction, and contact lens fitting fees are due at the time of services rendered. We accept all major credit cards (Discover, Visa, Master Card), cash and checks. PLEASE NOTE: There will be a $20 charge for any NSF (insufficient funds) checks returned to our office- plus any magistrate fees if further collection proceedings are deemed necessary.

**COLLECTION BALANCES:**

If you have had a previous collection balance or are presently in collection, it will be required that you pay your previous balance prior to being seen again or ordering any new materials.

**I have read the outlined financial policy. I understand and agree to this financial policy**

__________ **INTIAL**

### INSURANCE SIGNATURE ON FILE

I certify that the information given to me in applying for Insurance and/or Medicare benefits is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I request that payment of these benefits be made either to me or on my behalf to Thomas Eyecare & Optical, LLC, for any services and materials furnished. I authorize any holder of medical information about me to release it to the office for Medicare Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA1500 claim form or electronically submitted claim) my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

_________ **INTIAL**

### ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of Thomas Eyecare & Optical, LLC's Notice of Privacy Practices and have had sufficient time to read and understand its contents.

_________ **INTIAL**

### HIPAA AUTHORIZATION

Please list the family members or other persons, if any, whom may be informed about your general medical condition and your diagnosis (including treatment, payment, and health care operations.)

________________________________________________

________________________________________________

### SIGNATURE FOR ABOVE POLICIES

**I HAVE READ AND UNDERSTOOD ALL AREAS ABOVE. MY SIGNATURE BELOW INDICATES THAT I UNDERSTAND AND AGREE TO ALL POLICIES.**

__________________________________ ___________

Signature of Patient Date
(or Parent/Guardian if Patient is under 18)

__________________________________

Printed Name