

# Medical History Questionnaire

Name: \_\_\_\_\_ Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

\_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security #: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Last Eye Exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Male  Female Name of Medical Doctor: \_\_\_\_\_ Dr.'s Phone: \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Last Medical Exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Race:  American Indian or Alaskan Native  Asian  Black or African American  Decline to Specify  Hispanic

Native Hawaiian or Other Pacific Islander  White

Ethnicity:  Declined to Specify  Hispanic or Latino  Native Hawaiian/Other Pacific Islander  Not Hispanic or Latino

Communication Preference:  Text  Email  Postal  Telephone

## Medical History

Do you have any allergies to medications?  no  yes If yes, explain: \_\_\_\_\_

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies).

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List all major injuries, surgeries and/or hospitalizations you have had: \_\_\_\_\_

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury \_\_\_\_\_

Are you pregnant and/or nursing?  no  yes

Do you wear glasses?  no  yes If yes, how old is your present pair of lenses? \_\_\_\_\_

Do you wear contact lenses?  no  yes If yes, how old is your present pair of lenses? \_\_\_\_\_

Type of contact lenses:  Rigid  Soft  Extended Wear  Other Are they comfortable?  yes  no

If you don't wear contact lenses, are you interested in trying them?  yes  no

## Family History

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

\* Please turn this form over and complete side two \*

Do you drive?  no  yes If yes, do you have visual difficulty when driving?  no  yes If yes, please describe:

Do you use tobacco products?  no  yes If yes, type/amount/how long: \_\_\_\_\_

Do you drink alcohol?  no  yes If yes, type/amount/how long: \_\_\_\_\_

Do you use illegal drugs?  no  yes If yes, type/amount/how long: \_\_\_\_\_

Have you ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis

## Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?		NO	YES	?
<b>CONSTITUTIONAL</b>							
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>INTEGUMENTARY (Skin)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>NEUROLOGICAL</b>							
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>EYES</b>							
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>ENDOCRINE</b>							
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
				<b>EARS, NOSE, MOUTH, THROAT</b>			
				Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<b>RESPIRATORY</b>			
				Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<b>VASCULAR / CARDIOVASCULAR</b>			
				Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<b>GASTROINTESTINAL</b>			
				Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<b>GENITOURINARY</b>			
				Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<b>BONES / JOINTS / MUSCLES</b>			
				Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<b>LYMPHATIC / HEMATOLOGIC</b>			
				Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<b>ALLERGIC / IMMUNOLOGIC</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<b>PSYCHIATRIC</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date



Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First MI  
 Sex:  M  F Marital Status: \_\_\_\_\_ DL# \_\_\_\_\_ State Issued \_\_\_\_\_  
 If Student: Grade \_\_\_\_\_ School \_\_\_\_\_ Parent's Name (If Minor) \_\_\_\_\_  
 Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
 Names of children living with you: \_\_\_\_\_ Hobbies: \_\_\_\_\_  
 Responsible party for account: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Do you have insurance?  No  Yes Responsible party DOB: \_\_\_\_\_ Email: \_\_\_\_\_  
 If yes: Insurance Provider: \_\_\_\_\_ Insurance ID#: \_\_\_\_\_  
 Primary Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Who may we thank for referring you to this office? \_\_\_\_\_

- All professional services, which includes eye examinations and office visits must be PAID IN FULL when services are rendered.
- All materials, such as glasses and contact lenses must be PAID IN FULL before orders are placed.
- Any balance incurred as a result of not having a required referral or correct insurance information will be your responsibility.
- If your claim is denied for any reason or we have not received payment within 4-6 weeks from filing, you are responsible for the balance due within 30 days.
- We do not accept personal checks.

**MEDICARE-LIFETIME AUTHORIZATION**

I request payment of authorized Medicare benefits or other insurance benefits be made to either me or on my behalf to Dr. Horning for any services furnished to me by Dr. Horning. I authorize any holder of my medical information to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

By signing below, I acknowledge that I have read and agree to all of the above information:

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM**

I, \_\_\_\_\_, have reviewed/received a copy of A1A Family Eyecare's Notice of Privacy Practices.

Patient Name

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:





## Authorization to Release Information

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give consent to release this information to the family members indicated below. This consent form will not allow *AIA Family Eyecare* to release any other information to these family members. This authorization shall be in force and effect for the duration of 60 months, at which time this authorization will expire. You have the right to revoke this consent in writing.

I \_\_\_\_\_ authorize/allow *AIA Family Eyecare* to release my medical and/or billing information to the following individual(s):

1. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_
2. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_
3. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

The Florida Board of Optometry has adopted regulation 59-V3.010 that requires all patients to have dilation upon their initial examination. If you have not previously been dilated under our care then we would be required to perform the procedure.

Dilation of the eye expands the pupil and allows a more thorough examination of the retina than would be possible without the procedure.

These are a few things you should be aware of concerning dilation:

- Dilation will enlarge your pupils, which will decrease your ability to see reading distance.
- Dilation may make it difficult to see at a distance and allow sunlight to be very uncomfortable.
- Driving a vehicle may be difficult after dilation.
- If you elect to have the procedure, it will be an additional 30-45 minutes to do the examination, allowing sufficient time for the dilation drops to take effect.
- The effect of the dilation will last 4 to 6 hours.

**OPTOMAP RETINAL EXAM**

We are pleased to be able to offer our patients the Optomap Retinal Exam which allows our doctors to review an ultra-wide view of the retina (back of the eye). This evaluation can lead to the early detection of many eye diseases like glaucoma, macular degeneration, and retinal detachment. This technology can also detect systemic disorders such as diabetes, high blood pressure, cholesterol, and even cancer. This exam is painless, quick, and, in MANY cases, does NOT require dilating drops. Since this test is not yet covered by most insurance plans, there will be a small fee of \$39.00 for this test.

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS, after reading and understanding all aspects of the dilation procedure.

\_\_\_\_\_ I understand the above and elect to have my eyes dilated.

\_\_\_\_\_ I understand the above and elect NOT to have my eyes dilated.

\_\_\_\_\_ I understand the above and elect to have the retinal exam from Optomap.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_





## **Insurance and billing in regards to HMO plans**

A1A Family Eyecare does not participate with all health maintenance organizations (HMOs). In addition, an HMO will not typically pay for services without prior authorization from your insurance company. Your physician's referral alone does not necessarily constitute an authorization from your HMO.

A1A Family Eyecare requests a deposit for all unauthorized services. Deposits are based on an estimate of the cost of services you or your physician request and are not necessarily payment in full. Your actual charges may be greater or less than the deposit. If further testing or consultations are necessary, additional deposits may be required. If actual charges are less, the balance of the deposit will be refunded.

If insurance authorization for your services can be verified with your HMO prior to services being rendered, you will not be required to make a deposit for the authorized services. However, if additional services are necessary, further authorization or deposits will be required. Further authorizations may take a week or longer, depending on the necessity of review by the HMO's medical director or review committee. We will assist by filing insurance claims as services are incurred.

Please sign to acknowledge that you have read and understand this policy. Thank you!

x. \_\_\_\_\_

Date. \_\_\_\_\_

# Medicare Guidelines

## *GENERAL RULES*

The patient must pay an annual deductible toward any qualified health care before Medicare will pay for any services. After the deductible has been met for the year, Medicare will pay 80% of their “approved fee” and the patient pays 20% as a copayment plus any noncovered fees.

If you have supplemental insurance, it may cover the cost of the deductible and copayment. If your supplemental insurance is an approved “Medigap” policy, Medicare will automatically file your supplemental insurance claim for you. Not all supplemental policies are “Medigap” policies. You may be required to file a secondary insurance claim after you have received your Explanation of Benefits from Medicare.

Our Office will file your insurance claim for Medicare and accept payment directly from them if the services qualify for Medicare coverage (see exceptions below). Any charges Medicare will not cover are payable by the patient at each visit.

## *SPECIAL EXCEPTIONS*

1. Medicare does NOT cover the refraction portion of an eye exam. The refraction determines the eyeglass or contact lens prescription. **The cost of this non-covered service is \$39.00.** Payment is due at the time the services are rendered.
2. Medicare does NOT cover any services unless the doctor makes a medical diagnosis. If your only diagnosis is myopia, hyperopia, astigmatism or presbyopia, Medicare will not pay for any services.
3. Medicare may deny benefits if they feel you are receiving examinations too frequently, or are receiving exams by more than one doctor for the same illness.
4. Your signature on this form will serve as your “Signature on File” for processing Medicare forms.

Patient Name \_\_\_\_\_ Medicare ID# \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Supplemental Insurance Name \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

I HAVE READ AND UNDERSTAND THE ABOVE AND I AGREE TO PAY FOR SERVICES AND MATERIALS THAT MEDICARE DOES NOT COVER. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIANS OR SUPPLIER FOR SERVICES. ADDITIONALLY, I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

Patient Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_