PATIENT HISTORY QUESTIONNAIRE

PATIENT DEMOGRAPHICS Date: _____ Referred by: _____

Legal Last Name:_____ Legal First Name:_____ MI: _____

Street Address: _____Apt# ____City:_____ State:_____ Zip: _____

Cell Phone: (_____) _____ Home Phone: (_____) _____ Work Phone: (_____) _____

DOB: _____ Sex (Please circle): M / F Social Security #: _____ - _____ - _____

E-mail Address: _____ Education / Degree: _____

OK to text appointment reminders to your cell phone number? Yes No

EMERGENCY CONTACT INFO

Last Name:_____ First Name:_____ Phone: (_____) _____

INSURANCE INFORMATION

Employer: _____ Occupation: _____

Vision Insurance Name: _____ ID #: _____

Name of Primary Subscriber: _____ Subscriber DOB: _____

Primary Health Insurance Name: _____ ID #: _____

Secondary Health Insurance Name: _____ ID #: _____

Tertiary Health Insurance Name: _____ ID #: _____

Name of Primary Subscriber: _____ Subscriber DOB: _____

PERSONAL EYE INFORMATION

Do you use contact lenses for: _____ Distance _____ Reading _____ Both _____ Not at all

Do you use glasses for: _____ Distance _____ Reading _____ Both _____ Not at all

Do you experience: _____ Blurred Distance Vision with Glasses _____ Headache / Fatigue After Work

_____ Blurred Reading Vision with Glasses _____ Glare / Light Sensitivity

Type of contact lenses: _____ Last worn: _____

Have you ever been diagnosed with any of the following:

_____ Glaucoma	_____ Crossed Eye	_____ Dry Eye
_____ Diabetic Eye Disease	_____ Retinal Detachment	_____ Thyroid Eye Disease
_____ Macular Degeneration	_____ Bleeding in the Eye	_____ Lazy Eye
_____ Cataracts	_____ Blocked Tear Duct	_____ Eye Pain
_____ Double Vision	_____ Loss of Peripheral Vision	_____ Chronic Eye Infection

Have you had previous refractive surgery? _____ YES _____ NO Type of surgery: _____

Have you had previous ocular surgery? _____ YES _____ NO Type of surgery: _____

Have you had an eye injury? _____ YES _____ NO Date of Injury: _____

Details of injury: _____

MEDICAL INFORMATION

Primary Care Physician: _____ Phone: (_____) _____

Have you ever been diagnosed with any of the following: _____ *Healthy with no medical diagnosis*

_____ Diabetes	_____ High Blood Pressure	_____ Tuberculosis

_____ Thyroid Disease _____ Stroke _____ Kidney Disease
_____ Heart Disease _____ Arthritis _____ Cancer
_____ Asthma _____ Psychiatric Disorder _____ Immune Problems
_____ Chest Pain _____ Shortness of Breath _____ Regular Coughing
_____ Coughing up Blood _____ Bleeding Problems _____ Night Sweats
_____ Bloody Urine / Stool _____ Ringing in Ears _____ Loss of Balance / Dizziness
_____ Swollen glands _____ Unusual Weight Loss _____ Frequent Headaches

Other health issues not listed: _____

Please list all drug allergies: _____ _____ *No Known Drug Allergies*

Please list your current medications: _____ _____ *No Current Medications*

Please list any past surgeries: _____

How often do you drink alcohol? _____ Never _____ Occasional _____ Heavy

How often do you smoke? _____ Never _____ Occasional _____ Heavy

How often do you use illegal drugs? _____ Never _____ Occasional _____ Heavy

FAMILY HISTORY

Has anyone in your immediate family been diagnosed with the following:

_____ Glaucoma _____ Diabetes _____ Cataracts
_____ Heart Disease _____ Cancer _____ Lazy Eye
_____ Stroke _____ Heart Attack _____ Retinal Detachment
_____ Macular Degeneration _____ Retinitis Pigmentosa _____ High Blood Pressure

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HIPAA PRIVACY RULE

The HIPAA (Health Insurance Portability and Accountability ACT) notification describes in detail how your medical information may be used and disclosed. It also describes how you can access the information. I have been offered a copy of North County Laser Eye Associates HIPAA Notice of Privacy Practices. **Patient Initials: _____**

REFRACTION POLICY

Insurance companies will only pay for services that it determines to be "Medically Reasonable and Necessary." Refractions (examinations used to determine the prescription of your contacts and glasses) are most often deemed to be non-medical, and therefore are not covered by your health insurance. The cost of the exam is $85, and I understand that I will be held personally responsible for the payment. **Patient Initials: _____**

CONTACT LENS SERVICES POLICY

There may be separate fees incurred for contact lens services. Contact lens services are typically not considered a part of routine coverage. Coverage may depend upon the specific vision insurance plan and how the benefits are used. These fees may vary depending on the level of services rendered. **Patient Initials:_____**

INFORMATION REGARDING DILATING DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow a better view of the inside of your eye. These drops blur vision for a length of time and cause light sensitivity. I understand that my vision will be altered and I should use caution while driving or otherwise arrange for transportation. I hereby authorize North County Laser Eye Associates to administer dilating drops. **Patient Initials: _____**

PATIENT BALANCE RESPONSIBILITY

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account and for any professional or diagnostic services rendered as well as any glasses or contacts ordered. I authorize payment of medical benefits payable to the physician. A copy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or changes in any of the information provided on the patient information sheet. I understand that there will be a $25 late fee for any unpaid balance on my account after 2 balance due notices. I understand that my account will be sent to collections after the final letter, and that I am responsible for additional $25 administrative fees. I also authorized this office to release my spectacle or contact lens prescription at my request . **Patient Initials : _____**

_____ _____

Patient Signature (If patient is under 18, **Parent/Guardian** Signature) **Date**

Parent Guardian Printed Name_____

Welcome to our office! We are happy to have you as a new patient. Please take a moment to let us know how you found out about North County Laser Eye Associates:

__ Web Site (www.nclasik.com)

__ Facebook Page: North County Laser Eye Associates

__ Friend / family of an established patient (Name of Patient: _____)

__ MD Referral (Name of MD: _____)

__ Insurance plan directory (Name of Insurance plan: _____)

__ OD Referral (Name of OD: _____)

__ 1-800-SCRIPPS referral line

__ Carlsbad Forum signs

__ Post Card mailer

__ Yelp.com

__ Vitals.com

__ Health Grades.com

__ Wellness.com

__ Linked In.com

__ Angie's List.com

__ Everyday Health.com

__ Better Doctor.com

__ Rate MDs.com

__ U Compare Health Care.com

__ Yellow Pages

__ EyeMed / LCA Vision / Aetna Lasik program (Other laser vision company referral: _____)

__ Friend / family of employee (Name of Employee: _____)

__ Vendor web site (Crystalens, ReStor, VISX CustomVue) (Name of Vendor: _____)

__ Ximed Physicians Directory

__ San Diego Taiwanese Cultural Center

__ Walk-by

__ Other: _____