

ACKNOWLEDGMENT / HISTORY QUESTIONNAIRE

Name: _____ Birth Date: ____ / ____ / ____ Today's Date: ____ / ____ / ____

HIPPA Policy:

I understand Eye Associates of Little River, LLC participates in HIPPA compliance, and I have access to my HIPPA rights and office policy. I understand that Eye Associates of Little River, LLC will provide any protected health information that I request with my expressed written permission. **Initial:** _____

Please list the name, phone number, and relationship to whom we may release your protected health information.

1. _____ 2. _____

SS No.: ____ / ____ / ____ *we need at least the last four digits* Status: single married divorced widowed

Race: _____ Ethnicity: _____ Gender: _____ Do you have a power of attorney? Y / N

Do you live at an assisted living / memory care facility? Y / N Enrolled in a hospice care program? Y / N

In case of an emergency, whom do we contact? _____ Phone: (____) ____ - ____

Insurance Policy Owner: _____ Policy Owner Birth Date: ____ / ____ / ____

Policy Owner: _____ Relationship: Self / Spouse / Child

How may we contact you? (you may choose more than one) home cell work email text

Pharmacy: (local) _____ (mail-order) _____ May we import medications & e-prescribe Y / N

Allergies: _____

Last Eye Doctor: _____
City / State

Last Eye Exam: ____ / ____
Month Year

Current Medical Doctor: _____
City / State

Last Medical Exam: ____ / ____
Month Year

The office no-show fee is \$50* *Habitual no-shows will be terminated* *Balances will be transferred to the patient at 120 days

Authorization for Payment

I am authorizing assignment of my insurance rights and benefits directly to Eye Associates of Little River, LLC for services rendered and materials provided. I fully understand that I am responsible for any charges that may be denied or not covered by my insurance company.

Consent for Treatment

By signing this form, I consent to treatment for the patient. I give my permission for the doctor to examine, diagnose, and indicate treatment as deemed appropriate. I understand that my doctor will answer any questions to the best of their ability and I will be given an option to consent to any and all treatment.

Acknowledgment

All fees are due at time of service unless assignment has been approved by your vision/medical insurance. Fees include copays, deductibles, refractions fees, contact lens fees, etc. We do not participate in payment plans. Accounts with open balances will not be seen until account is satisfied. Collections and returned check fees apply. Accounts will be sent to collections after 120 days.

SIGNATURE: X _____ DATE: _____

Social History:

Do you drive? yes no Drive during the day? yes no Drive during the night? yes no

Are you currently pregnant or nursing? yes no

What is your tobacco usage? current / former / never

Do you use recreational drugs? yes no

Do you drink alcohol? yes no how many drinks in a week _____

Have you ever been exposed to a blood-borne pathogen: HIV AIDS Hepatitis C

Personal Eye History:

Check all that apply to you:

- | | | |
|---|---|---|
| <input type="checkbox"/> Reading Difficulty | <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Lazy Eye | <input type="checkbox"/> Diabetic Bleeding | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Glare at night | <input type="checkbox"/> Dry Eyes |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Itchy/ Watery eyes | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Glare and Halos | <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Light sensitivity |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Ocular migraines | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Recurrent styes | <input type="checkbox"/> Dry Eye Syndrome | <input type="checkbox"/> _____ |

Do you wear prescription glasses? yes no Do you wear drug store reading glasses? yes no
Do you have history of needing **PRISM** in your prescription glasses for double vision / vision therapy? yes no
Do you wear contact lenses? yes no If yes, soft hard Brand? _____ How Old? _____

Have you had any eye surgeries? LASIK / RK / PRK Muscle Surgery Glaucoma Surgery
 Cataract Diabetic Laser Retinal Detachment
 Eye Injections Eyelid Lift Punctal Plugs

Family vision history: Blindness Cataract Glaucoma Macular Degeneration dry / wet
 Lazy Eyes Crossed Eyes Fuchs' Dystrophy Other _____

Medical History:

Please list any major surgeries, hospitalizations, and/or serious accidents:

Auto Immune

- | | | | |
|---|---------------------------------------|---|--|
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Sarcoidosis | <input type="checkbox"/> Sjogren's Syndrome | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Psoriatic Arthritis |

Neurological / Brain

- | | | | |
|---|---|---|--------------------------------------|
| <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Dementia | <input type="checkbox"/> Stroke | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Multiple Concussions | <input type="checkbox"/> Pseudotumor |

Cardiovascular

- | | | | |
|--|---------------------------------------|--------------------------------|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> A-Fib | <input type="checkbox"/> High Cholesterol |
|--|---------------------------------------|--------------------------------|---|

Endocrine

- | | | | |
|-----------------------------------|----------------------------------|--|-------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Grave's Disease | <input type="checkbox"/> PCOS |
|-----------------------------------|----------------------------------|--|-------------------------------|

Mental Health / Behavioral

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> ADHD | <input type="checkbox"/> Autism Spectrum | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Chemical Imbalance | <input type="checkbox"/> _____ | |

Respiratory

- | | | | |
|---------------------------------|---|---|---------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD / Emphysema | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Tuberculosis |
|---------------------------------|---|---|---------------------------------------|

Skin

- | | | | | |
|---------------------------------|------------------------------------|----------------------------------|-------------------------------|---------------------------------|
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Acne | <input type="checkbox"/> Cancer |
|---------------------------------|------------------------------------|----------------------------------|-------------------------------|---------------------------------|

Ear / Nose / Throat

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Chronic Allergies | <input type="checkbox"/> Sleep Apnea |
|---|--|--------------------------------------|

Gastrointestinal

- | | |
|---|------------------------------|
| <input type="checkbox"/> GERD / Acid Reflux | <input type="checkbox"/> IBS |
|---|------------------------------|

Kidney / Bladder:

- | | | |
|--|--|---|
| <input type="checkbox"/> Recurrent UTI | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Kidney Disease |
|--|--|---|

Lymphatic/ Hematological

- | | | | |
|---------------------------------|--|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bleeding / Clotting | <input type="checkbox"/> Lymphoma | <input type="checkbox"/> Leukemia |
|---------------------------------|--|-----------------------------------|-----------------------------------|

Cancer – any organ: _____

Other (please describe): _____

SIGNATURE: X _____ DATE: _____