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New Patient History Questionnaire

Full Name: _____ Today's Date: ___/___/___

Primary Care Doctor: _____ Birth Date: ___/___/___

Previous Eye Doctor: _____ Last Medical Exam: ___/___/___

Referring Doctor, if any: _____ Last Eye Exam: ___/___/___

Ocular History

Do you wear glasses? ☐ Full Time ☐ Part Time ☐ Never
What kind? ☐ Single Vision ☐ Bifocals ☐ Trifocals ☐ Progressive ☐ Computer/Workspace
What activities do you wear your glasses for? ☐ Driving ☐ Reading ☐ Computer ☐ Sunglasses

Do you wear contact lenses? ☐ Yes ☐ No
If yes, what type? ☐ Soft ☐ RPG ☐ Toric ☐ Multifocal ☐ Extended Wear Brand: _____
Do you wear them ☐ Full Time ☐ Part Time
Do you sleep in your contacts? ☐ Yes ☐ No

Do you use eye drops? ☐ Yes ☐ No
If yes, what brand? _____

Do you use the computer for extended periods of time? ☐ Yes ☐ No - How many hours per day? _____

Are you having any visual difficulties? ☐ Yes ☐ No
If yes, please explain: _____

Are you currently experiencing any of the following problems with your eyes? **Check the box if "Yes".**

☐ Blurred Vision	☐ Flashes/Floaters	☐ Redness
☐ Loss of Vision	☐ Halos/Glare/Light Sensitivity	☐ Excess Tearing
☐ Loss of Side Vision	☐ Dryness	☐ Eye Pain or Soreness
☐ Poor Night Vision	☐ Sandy or Gritty Feeling	☐ Mucus Discharge
☐ Double Vision	☐ Burning	☐ Inflammation of the Eyelid
☐ Tired Eyes	☐ Itching	☐ Styes or Chalazion

Ryan Schott, OD
Optometry
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Kindred Optics
At Maitland Vision

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Have you ever been diagnosed with any of the following ocular problems? **Check the box if "Yes".**

☐ Cataracts ☐ Glaucoma ☐ Retinal Detachment
☐ Crossed Eyes ☐ Lazy Eye/Amblyopia ☐ Dry Eye
☐ Eye Injury ☐ Macular Degeneration ☐ Other _____

Medical History

Medications	**Condition**
_____	_____
_____	_____
_____	_____
_____	_____

Please attach list of any additional medications

Over the counter medications and/or nutritional supplements: _____
Are you allergic to any medications? ☐ No ☐ Yes - Which ones? _____
List any eye surgeries you have had: _____

REVIEW OF SYSTEMS Please check the box beside any problem you currently have, or have had, in the following areas:

ALLERGIC/IMMUNOLOGIC
☐ Environmental
☐ Animal Dander
☐ Autoimmune _____
☐ Other: _____

CARDIOVASCULAR/CARDIAC
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Other: _____

NEUROLOGICAL
☐ Migraines
☐ Stroke
☐ Other: _____

MUSCULOSKELETAL
☐ Arthritis
☐ Fibromyalgia

CONSTITUTIONAL
☐ Cancer

ENDOCRINE
☐ Diabetes - Type: _____
☐ Thyroid Dysfunction

Any other medical conditions you feel might be affecting your eyes: _____
_____

FAMILY HISTORY Please note any family history for the following conditions

	RELATION TO YOU
☐ Glaucoma	_____
☐ Macular Degeneration	_____
☐ Retinal Detachment	_____
☐ Blindness	_____
☐ Diabetes	_____

PERSONAL SOCIAL HISTORY Please check the appropriate box next to the following:

Tobacco ☐ Yes ☐ No - Stopped: _____ <1 pk/day – 1 pk/day – >1 pk/day – chew
Alcohol ☐ Yes ☐ No Social 1/day >1/day

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Name: _____ Date of Birth: _____/_____/_____

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

Home #: _____ Cell #: _____ Email: _____

Emergency Contact: _____ Phone #: _____

Insurance

Primary Medical Insurance: _____ Policy #/Member ID: _____

Primary Member Name: _____ Primary Member DOB: _____/_____/_____

Your Relationship to Primary Member: spouse | child | other (please explain) _____

Secondary Medical Insurance: _____ Policy #/Member ID: _____

Primary Member Name: _____ Primary Member DOB: _____/_____/_____

Your Relationship to Primary Member: spouse | child | other (please explain) _____

VSP: ☐ Yes ☐ No Vision Insurance Member ID/Last 4 Digits of Social Security #: _____

Primary Member Name: _____ Primary Member DOB: _____/_____/_____

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Office Policies

Any fees not covered by insurance are due at the time of service. All contact lens, optical products and low vision devices are to be paid in full upon ordering. Custom optical orders are non-refundable. They may be returned for credit within 30 days of purchase. There is no refund for services provided.
If you have insurance coverage, Kindred Optics at Maitland Vision will file your claim on your behalf. Any deductibles or copays are due at the time services are rendered. The doctor has the final decision as to whether the exam will be filed with your medical insurance or your routine vision insurance. Any services not payable by your insurance are due 30 days after we receive the Explanation of Benefits.
Returned NSF checks will be charged a service fee of $50.00.
If you need to cancel or change an appointment, please give us at least 24-hour notice. Cancellations or no shows with less than 24-hour notice may be assessed a $50.00 fee.

Initials: _____

Lifetime Insurance Authorization

Medicare:
I request that payment of authorized Medicare benefits and other supplemental insurance being made either to me or on my behalf go to Kindred Optics at Maitland Vision for any services provided. I authorize medical information about me to be released to the Health Care Financing Administration and its Agents as needed to determine benefits payable for related services.
I have been notified by Kindred Optics at Maitland Vision that Medicare is likely to deny payment for the refraction, glasses, and low vision devices because Medicare does not usually pay for these services and products. Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862(a)(1) of Medicare Law. If Medicare determines that a particular service or product is not "reasonable and necessary" under Medicare Law, Medicare will deny payment for that service or product. If Medicare denies payment, I agree to personally be responsible for that service or product.

Initials: _____

Other Insurance:
I authorize the release of medical information necessary to determine benefits payable for related services under my health insurance policy. I request that payment of authorized medical benefits be assigned directly to Kindred Optics at Maitland Vision under the terms of my health insurance policy. I agree that any balance not covered by my health insurance policy will be payable by me.

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Authorization to Disclose Protected Health Information

Our office wishes to safeguard your Personal Health Information (PHI). In order to comply with HIPAA regulations, we are making you aware of your rights in handling your Protected Personal Health Information.

Information covered by this authorization includes:

- Prescription information
- Insurance information
- Details concerning your ocular condition

If you would like the release of your records and allow us to talk with someone other than yourself, you must list those individuals.

Name	Phone #	Relationship

_____ I authorize Kindred Optics at Maitland Vision to leave a message on my answering machine or cell phone concerning Personal Health Information.

This authorization is for an indefinite time. I am aware that if I wish to revoke this authorization or any part of it I may do so at any time in writing.

I Do / Do Not want to receive a copy of Kindred Optics at Maitland Vision's HIPAA Notice of Privacy Practices.

Signature: _____ Date: _____

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About Your Insurance

There are two types of insurance that will help pay for your eye care services and products. You may have both types and our office participates in both.

1. **Vision discount plans** (such as **VSP - Vision Service Plan**)
2. **Medical insurance** (such as **Blue Cross/Blue Shield, Medicare, United Health Care, and others**).

- Vision plans **only** cover routine vision wellness exams, along with eyeglasses and contact lenses. Vision plans do **not** cover medical eye care (the diagnosis, management or treatment of eye health problems).
- Medical insurance (or health insurance) must be used for medical eye care.
- A vision wellness exam is defined when the only diagnosis is refractive in nature (myopia or astigmatism, for example). A medical eye exam is when the diagnosis is anything other than refractive (glaucoma, cataract, headaches, dry eye syndrome, infection, and many others).
- Medical insurance must be used if you have an eye health problem or a systemic health problem that has possible ocular complications, such as diabetes or potentially toxic medications (Plaquenil for example). Your doctor will determine if these conditions apply to you, but some are determined by your case history.
- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called **coordination of benefits** to do this properly and to minimize your out-of-pocket expenses.
- We will bill your vision plan or medical insurance for services if we are a participating provider for that company. If we are not a provider, you may submit your own claim for reimbursement of the fees you pay. We will obtain an estimate of benefits in advance so we can tell you what is covered. If some fees are not paid by your insurance, such as copays, deductibles, or non-covered services, we will collect those fees at the time of service.

Please provide your insurance cards to our staff member so we can make a copy. We need to have your Medical insurance card or Medicare card on file in case we should need it in the future for billing your insurance to help cover the cost of your visit. Thank you for your understanding.

I have read and accept these policies.

_____ _____

Patient signature (parent if child) Date

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