



Patient History Questionnaire

Office use only:
Chart ID _____
Ins _____
Photos _____

PLEASE PRINT

Last Name: _____ First: _____ MI: _____ Goes
by: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Gender: _____ SS#: _____

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

Guardian (if under 18): _____ Relation: _____ Date of Birth: _____

E-Mail: _____

Family Doctor: _____ Phone: (____) _____

Occupation: _____ Employer: _____

Last Eye Exam: ____/____/____ Last Medical Exam: ____/____/____

Alternate Contact: _____ Relationship: _____ Phone: (____) _____

Chief complaint today: _____ How did you hear about us? _____

Medical History

Height: _____ Weight: _____ Do you smoke? Yes ___ No ___ Previously ___ Do you drive? ___

Do you have any allergies to Medications: ___ Yes ___ No *If Yes, Explain _____

List any medications with current dosages that you are currently taking _____

Check any of the following that you have had: Prominent Eyes ___ Crossed Eyes ___ Lazy Eye ___
Eye Surgery ___ Eye Infection ___ Retinal Disease ___ Glaucoma ___
Cataracts ___ Eye Injury ___ Drooping Eyes ___

Are you pregnant? ___ Y ___ N

Do you wear glasses ___ Y ___ N If yes, how old is your present pair of glasses? _____ Years

Do you wear contacts ___ Y ___ N If yes, how old is your present pair of contact lenses? _____ Weeks

What Brand of contacts are you currently wearing? _____ Are they comfortable? ___ Y ___ N

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

Do you currently or do you often have any problems in the following areas:

CONSTITUTIONAL

- Fever
- Weight Loss/Gain

INTEGUMENTARY

- Skin Changes

NEUROLOGICAL

- Headaches
- Migraines
- Seizures

EYES

- Loss of Vision
- Blurred Vision
- Distorted Vision/Halos
- Loss of Side Vision
- Double Vision
- Dryness
- Mucous Discharge
- Redness
- Itching
- Burning
- Foreign Body Sensation
- Excess Tearing
- Glare/Light Sensitivity

EYES (continued)

- Eye Pain or Soreness
- Chronic Infection of Eye or Lid
- Styes or Chalazion
- Flashers
- Floaters in Vision
- Tired Eyes

RESPIRATORY

- Asthma
- Chronic Bronchitis
- Emphysema
- Sleep Apnea

EARS, NOSE, THROAT and MOUTH

- Seasonal Allergies/Hay Fever
- Sinus Congestion
- Runny Nose
- Post-Nasal Drip
- Chronic Cough
- Dry Throat/Mouth
- Ringing in Ears
- Ear Pain or Infection
- Hearing Aids
- Deaf

VASCULAR, CARDIOVASCULAR

- Diabetes
- Heart Disease
- High Blood Pressure
- High Cholesterol

GASTROINTESTINAL

- Diarrhea
- Constipation

GENITOURINARY

- Gonads/Kidney/Bladder

BONES/JOINTS/MUSCLES

- Rheumatoid Arthritis
- Muscle Pain
- Joint Pain

LYMPHATIC/HEMATOLOGICAL

- Anemia
- Bleeding Problems

ENDOCRINE

- Thyroid Issues/Other Glands

ALLERGY/IMMUNE

- Allergies, Immune Disorders

PSYCHIATRIC

- Psychiatric
- Special Needs

If you answered "?" to any of the above or have a condition not listed, please explain.

Family History

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

- | DISEASE/CONDITION | Y | RELATIONSHIP |
|----------------------------|---|--------------|
| Blindness | | |
| Glaucoma | | |
| Crossed Eyes | | |
| Macular Degeneration | | |
| Retinal Detachment/Disease | | |

- | Y | RELATIONSHIP |
|---|--------------|
| | |
| | |
| | |
| | |
| | |

If other, explain

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Insurance Information

Many people have both vision insurance and medical insurance. These plans are very different in terms of the services that they cover and it is important for our patients to understand those differences. Vision plans (VSP, Spectera, EyeMed, Davis etc) are mainly designed to determine a prescription for glasses are not intended for managing medical conditions. When a medical condition is present which is impacting the health or your eyes or which has the potential to impact the health of your eyes, it is necessary to file the visit with your major medical insurance (BCBS, Aetna, UHC, Cigna, etc) and the co-pays, deductibles, and/or co-insurance for that insurance plan will apply. Insurance carriers set these rules and our office is required to follow them. In most cases, there is no way to know prior to the examination which type of insurance our office will need to file for you.

1. If you have ANY problems or complaints that may be attributable to a medical condition which requires a more in-depth investigation and additional medical decision-making to rule out any underlying eye disease, we will accordingly bill your MEDICAL insurance, NOT your vision plan. These include, but are not limited to:

- Sudden Loss of Vision
- Eye Pain or Redness
- New Flashes or Floaters
- Double Vision

2. There are a variety of systemic conditions that can profoundly and permanently affect a patient's vision that require a more in-depth investigation, which may include additional testing, follow up visits, and reports to your primary care physician. This type of examination is NOT covered under most vision plans, and we will bill your MEDICAL insurance, NOT your vision plan. These include, but are not limited to:

- Diabetes
- Use of High Risk Medications such as Plaquenil, Trikafta, etc
- When Impacting the Eyes:
 - Hypertension
 - Thyroid Disease

3. If you have previously been diagnosed by another eye doctor for any eye issues that require medical decision-making, testing or management, we will bill your MEDICAL insurance, NOT your vision plan. These include, but are not limited to:

- Cataracts
- Macular Degeneration
- Glaucoma/High Eye Pressure
- History of Other Retinal Disease

We make every effort to be on every major insurance for your convenience and we will file those claims for you. At times we can coordinate your vision and medical insurance benefits. In the event that we do not take your insurance we will provide you with an itemized receipt so that you may file with your carrier for reimbursement. If you have any questions, please let us know.

I understand the paragraph above and authorize Mallard Eye Care to file my insurance by the above guidelines.

Patient Name (printed): _____

Signature: _____ Date: _____



Previous Patient Acknowledgement Form

Retinal Photos

A retinal photo is a picture of the inside of the eye. This technology gives our doctors a better view of the health of your eye. While this is **not** a replacement for dilation, should you choose to not have your eyes dilated we strongly recommend taking the photos. **If you have a history of eye disease, diabetes, high blood pressure, high cholesterol, or family history of eye disease we strongly recommend taking the photos.**

Retinal photos are included in the OUT OF POCKET (non-insurance) exam fees. If you are using vision insurance, these photos are typically not covered and the fee is \$30. If you are using medical insurance and there is a medical reason to take the photos, we will bill them to your insurance for you. These photos maybe processed towards your deductible, co-insurance or have a separate copayment. Once your insurance processes the claim based on your benefits; we will send you a statement of anything that is due from you.

Sometimes dilation is still necessary, and the doctor will discuss it with you if it is required for your exam.

_____ I would like to have the retinal photos taken

_____ I prefer not to have the retinal photos taken,
unless the doctor and I agree they are necessary

HIPAA Privacy Policy

I acknowledge that my medical history may be stored online through Mallard Eye Care's computer system and Dr. First R-Copia E-prescribing. I understand that I may request a detailed copy of Mallard Eye Care's HIPAA Privacy Practices at any time.

****I acknowledge that my personal and medical information can only be discussed with those listed below.****

Patient Signature (or Guardian, if applicable): _____ **Date:** _____

Names:

Relationship:

Date of Birth:



Thank you for choosing Mallard Eye Care. We are dedicated to helping you with your vision care.

Insurance

Your insurance policy is a contract between you and your insurance company. Any balance remaining will be your responsibility and must be paid in full by you. We will bill your insurance for you as a courtesy, but all copays and deductibles are due at the time of service. We will do our very best to answer all your questions about your insurance, but please remember, we cannot guarantee their coverage or benefits.

Appointments

As a courtesy we will send you a reminder of your appointment. We will make every effort to contact you, please provide us with a number that you are confident we will be able to reach you. If you fail to show to an appointment, we will charge you \$40 for that missed appointment or appointment that is not cancelled within 24 hours' notice.

Financial Policy

We appreciate you choosing us for your vision care. We will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received.

- I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations.
- I understand that if I have an insurance co-payment, I am expected to make payment when checking out for my appointment.
- I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. They vary by each plan. Mallard Eye Care, is not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving the services. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred.

Thank you for your understanding and cooperation with this policy. It is our privilege to provide your vision care.

I have read and understand this Financial Policy stated above and agree to accept full responsibility as described above.

Patient Name: _____

Patient/Responsible Party Signature

Date