MEDICAL HISTORY FORM

PATIENT DEMOGRAPHIC INFORMATION

I am a: New Patient Existing Patient
(Please circle)

Legal Name: _____ Preferred Name: _____ Date of Birth: _____
(First, Middle Initial, Last)

Sex: M F Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Preferred Contact: Home Work Cell Email Text
(Please circle)

SSN: _____ Marital Status: _____ Ethnicity: _____ Race: _____

Occupation: _____ Hobbies: _____

Primary Care Physician: _____ Primary Care Physician Office Phone: _____

Other Specialist: _____ Other Specialist Office Phone: _____

Preferred Pharmacy: _____ Preferred Pharmacy Location/Phone: _____

Date of Last Eye Exam: _____ Name of Last Eye Doctor: _____

New Patients Only: How were you referred to our office? _____

INSURANCE INFORMATION

Medical Insurance: _____ Primary Policy Holder (PPH) Name: _____

Vision Insurance: _____ PPH Last 4 SSN: _____ PPH Date of Birth: _____

MEDICATION INFORMATION

Please list all medications (names, dosages, and approx. start date) you are currently taking below. If none, leave blank.

☐ None ☐ See attached list

_____

_____

_____

_____

Do you have any allergies to medication? ☐ Yes ☐ No

If yes, please list them here: _____

_____

_____

REVIEW OF SYMPTOMS (circle any that apply to you)

Females: Are you pregnant? Yes No Nursing? Yes No

Constitutional: None Fatigue Fever Weight Loss Other _____

Cardiovascular: None Murmur Palpitations Hypertension Stroke Cholesterol Heart Disease Other _____

Respiratory: None Histoplasmosis Asthma Emphysema COPD Other _____

Gastrointestinal: None Jaundice Crohns Ulcers IBS Acid Reflux Other _____

Genitourinary: None Kidney Disease Liver Disease Bladder Prostate Other _____

Bones/Joints/Muscles: None Osteoarthristis Rheumatoid Arthritis Fibromyalgia Other _____

Integumentary (skin): None Rash/Sores Herpes Zoster/Shingles Rosacea Other _____

Neurological: None Weakness Numbness Memory Loss Headaches Migraines Seizures MS Other _____

Psychiatric: None Anxiety Depression Bipolar PTSD Other _____

Endocrine: None Diabetes Thyroid Other _____

If diabetic, last blood sugar level? _____ Last A1C? _____

Lymphatic/Hemotologic: None Cancer Leukemia Anemia Bleeding Other _____

Allergic/Immunologic: None Hayfever Seasonal Allergies Autoimmune Disease Other _____

OCULAR HISTORY

Do you wear glasses? Yes No How old are your current glasses? _____

Do you wear contacts? Yes No Current brand? _____

If not, are you interested in contacts? Yes No (Note: Contact Lens Evaluations are an additional fee. Please see policy)

Have you ever been monitored/notified of any of the following conditions? Cataracts Lazy Eye Dry Eyes

Color Blindness Macular Degeneration Retinal Detachment Glaucoma Other _____

Prior Eye Surgeries: Yes No List, if yes: _____

How many hours, approximately, per day do you spend on a computer/tablet/cell phone? _____

Are you experiencing any of the following ocular symptoms? Itch Dryness Redness Fatigue Watery Eye Discharge

Flashes Floaters Vision Fluctuations Pain Light Sensitivity Other _____

FAMILY MEDICAL HISTORY

(circle any that apply to your family and list the relative affected)

Blindness: Yes No Relative: _____

Glaucoma: Yes No Relative: _____

Cataracts : Yes No Relative: _____

Diabetes: Yes No Relative: _____

Macular Degeneration: Yes No Relative: _____

Retinal Detachment: Yes No Relative: _____

High Blood Pressure: Yes No Relative: _____

Cancer: Yes No Relative: _____

Other Significant Conditions: Yes No Relative: _____

If yes, please specify: _____

SOCIAL HISTORY

Do you smoke? Yes No

Have you ever smoked? Yes No

How much smoking per day? _____

Do you use any other drugs? Yes No

Specify: _____

Do you consume alcohol? Yes No

Frequency: _____

Have you ever been exposed to the following? (circle any that apply)

Syphilis Tuberculosis Gonorrhea HIV/AIDS Hepatitis

HIPAA Acknowledgment of Privacy Practices

I am aware that Breslow Eye Care, LLC abides by the HIPAA privacy policy, thereby keeping my personal and medical information confidential. I have notified a staff member if I would like a printed copy of our policy to keep for my records. Privacy regulations require that we receive written request from our patients so that we can discuss your medical information with a spouse, family member, or friend. Please ask a staff member for the Release of Information form if interested.

X _____ _____

Patient Signature (or Guardian) Date

Insurance Agreement and Signature on File

I authorize the release of any medical or other information necessary to process my insurance claim. I authorize payment of benefits directly to Breslow Eye Care, LLC. Payments for all services, as estimated by my insurance company, will be due at the time services are rendered. I understand that Breslow Eye Care, LLC will make an effort to obtain detailed benefits information from my insurance company(ies). However, I am responsible for any deductible, copay, share of cost, or service not covered by my insurance, even if it is not collected at the time of service.

X _____ _____

Patient Signature (or Guardian) Date

Advanced Beneficiary Notice (ABN)

I understand that my insurance will only pay for covered services. The fact that my insurance will not pay for a particular service does not mean that I should not receive it. I have been informed and educated by the doctors' staff of the benefits of any additional testing and any fees associated with this testing and I agree to be fully responsible for the payment.

X _____ _____

Patient Signature (or Guardian) Date

Contact Lens Policy

I understand that contact lenses are an addition to the standard health exam and, as such, there will be an additional fee associated with the fitting. I understand that my insurance may not cover all of this fee. ***My evaluation fee covers any follow-up visits related to routine contact lens fitting completed within 60 days,*** subject to discretion. It is my responsibility to complete all follow-up care within this time, following the timeline set by the doctor. ***Additional fees may be accumulated for care outside of the 60 days or any visits related to medical complaints.*** I understand that contact lenses are a medical device and my prescription cannot be finalized until all follow-up care is completed. Per Ohio law, contact lens prescriptions expire 1 year from the date of the evaluation and cannot be extended.

I acknowledge that I have been instructed in the proper manner of insertion, removal, and care for my contact lenses. Contact lenses are a medical device sitting on living tissue. I have been made aware of the risks associated with over-wearing my contact lenses, and have asked for clarification if needed. ***I understand that noncompliance in wearing schedule may result in serious injury to my eyes.***

I understand that any prolonged pain or redness should be reported to this office immediately. Failure to do so may result in serious injury to the eye and possible permanent loss of vision. I understand that follow-up care is of the utmost importance and it is my responsibility to ensure that I follow the plan set by my doctor.

X _____ _____

Patient Signature (or Guardian) Date

_____

Patient Name (Print)