CLEARVIEW FAMILY EYECARE

Welcome!

Welcome to our practice. If you have any questions or need assistance with this form, please let us know.

Patient Name: _____ Today's Date: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Work Phone: _____
Birth Date: _____ Age: _____ Social Security #: _____ Sex: ☐ Male ☐ Female
Guardian (If Applicable): _____ Occupation: _____
Spouse's Name: _____ Employer: _____

What hobbies or specialty areas at home/work have specific visual needs? (i.e. reading, reading music, using a computer, working overhead, target shooting, playing golf, scuba diving, sewing, needlepoint, fishing, etc.)

_____

Email: _____

Medical History Questionnaire

MEDICAL HISTORY

Do you have any allergies to medications? ☐ no ☐ yes If yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over-the-counter medications and home remedies):

_____

_____

_____

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

_____

_____

List any of the following you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant and/or nursing? ☐ no ☐ yes

Do you wear glasses? ☐ no ☐ yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ☐ no ☐ yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other Brand: Are they comfortable? ☐ yes ☐ no

FAMILY HISTORY

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

DISEASE/ CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/ Disease	☐	☐	☐	_____
Arthritis/ Lupus	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other _____	☐	☐	☐	_____

Do you have visual difficulty when driving? ❒ no ❒ yes If yes, please describe:

_____

How often do you experience headaches? ❒ Daily ❒ Weekly ❒ Intermittently ❒ Rarely ❒ Never

What do you feel is the cause(s) of these headaches? ❒ Sinus/Allergies ❒ Stress ❒ Diet/Caffeine ❒ Sleep ❒ Vision

Review of Systems

Do you currently, or have you ever had any PROBLEMS in the following areas:

	NO	YES	?
CONSTITUTIONAL			
Acute Fever, Weight Loss/Gain	❒	❒	❒
INTEGUMENTARY (Skin)	❒	❒	❒
NEUROLOGICAL			
Dizziness	❒	❒	❒
Migraines	❒	❒	❒
Seizures	❒	❒	❒
EYES			
Loss of Vision	❒	❒	❒
Blurred Vision	❒	❒	❒
Distorted Vision/Halos	❒	❒	❒
Loss of Side Vision	❒	❒	❒
Double Vision	❒	❒	❒
Dryness	❒	❒	❒
Mucous Discharge	❒	❒	❒
Redness	❒	❒	❒
Sandy or Gritty Feeling	❒	❒	❒
Itching	❒	❒	❒
Burning	❒	❒	❒
Foreign Body Sensation	❒	❒	❒
Excess Tearing/Watering	❒	❒	❒
Glare/Light Sensitivity	❒	❒	❒
Eye Pain or Soreness	❒	❒	❒
Chronic Infection of Eye or Lid	❒	❒	❒
Styes or Chalazion	❒	❒	❒
Flashes/Floaters in Vision	❒	❒	❒
Tired Eyes	❒	❒	❒
ENDOCRINE			
Thyroid/Other Glands	❒	❒	❒

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	❒	❒	❒
Sinus Congestion	❒	❒	❒
Runny Nose	❒	❒	❒
Post-Nasal Drip	❒	❒	❒
Chronic Cough	❒	❒	❒
Dry Throat/Mouth	❒	❒	❒
RESPIRATORY			
Asthma	❒	❒	❒
Chronic Bronchitis	❒	❒	❒
Emphysema	❒	❒	❒
VASCULAR / CARDIOVASCULAR			
Diabetes	❒	❒	❒
Most Recent HbA1c? _____			
Most Recent Blood Sugar? _____			
Heart Pain	❒	❒	❒
High Blood Pressure	❒	❒	❒
Vascular Disease	❒	❒	❒
GASTROINTESTINAL			
Diarrhea	❒	❒	❒
Constipation	❒	❒	❒
GENITOURINARY			
Genitals/Kidney/Bladder	❒	❒	❒
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	❒	❒	❒
Muscle Pain	❒	❒	❒
Joint Pain	❒	❒	❒
LYMPHATIC / HEMATOLOGIC			
Anemia	❒	❒	❒
Bleeding Problems	❒	❒	❒
ALLERGIC / IMMUNOLOGIC	❒	❒	❒
PSYCHIATRIC	❒	❒	❒
OTHER NOT LISTED _____			
DO YOU USE TOBACCO PRODUCTS?	❒	❒	

I certify that I have answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits for services rendered. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or those of my dependents. I understand that all fees are due at the time of service and are non-refundable.

X _____ _____

SIGNATURE OF PATIENT (or parent if patient is a minor) DATE

CLEARVIEW FAMILY EYECARE

Insurance Information

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

Vision Insurance

Vision Insurance Company: □ None □ VSP □ EyeMed □ Spectera □ Davis □ Other _____
Insurance ID #: _____ Group #: _____
Insured's Relationship to Patient: □ Self □ Parent □ Spouse □ Other _____
Insured Name (if not patient): _____ Insured Birth Date: _____
Insured Social Security # (last 4): _____ Insured Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

Primary Medical Insurance

Medical Insurance Company: □ None □ Medicare □ BCBST □ Cigna □ Other _____
Insurance ID #: _____ Group #: _____
Insured's Relationship to Patient: □ Self □ Parent □ Spouse □ Other _____
Insured Name (if not patient): _____ Insured Birth Date: _____
Insured Social Security # (last 4): _____ Insured Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

Additional (Supplemental) Medical Insurance

Medical Insurance Company: □ None □ Medicare □ BCBST □ Cigna □ Other _____
Insurance ID #: _____ Group #: _____
Insured's Relationship to Patient: □ Self □ Parent □ Spouse □ Other _____
Insured Name (if not patient): _____ Insured Birth Date: _____
Insured Social Security # (last 4): _____ Insured Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

Vision Insurance vs Medical Insurance

Many people have vision insurance and medical insurance. They are very different in terms of the services they cover and it's important for our patients to understand those differences. Vision coverage (VSP, Spectera, EyeMed, etc) is mainly designed to determine a prescription for glasses and is not equipped to deal with complex medical conditions and/or diagnoses. It does allow for screenings of conditions, but once they are determined, then medical insurance is filed on those services. When a medical condition is present (such as diabetes, cataracts, dry eye, floaters, etc.) it is necessary to file the visit with your major medical carrier (BCBS, Aetna, UHC, Cigna, etc) and the co-pays for that insurance will apply as well as any non-covered service. Insurance carriers set these rules and our office is obliged to follow them. In most cases, there is no way to know prior to the examination which type of insurance our office will be able to file for you. We make every effort to be on every major carrier for your convenience and we will file those claims for you. 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 direct reimbursement.

I understand the paragraph above & authorize Clearview Family Eyecare to file my insurance by the above guidelines.

Signature: _____ Date: _____