Entyre VISION CARE

Patient History Questionnaire

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name _____ First Name _____ MI _____
Address _____ City _____ State_____ Zip _____
Work Phone _____ Home Phone_____
Date of Birth_____ Occupation_____ Employer _____
Emergency Contact Name _____ Phone Number_____
Date of Last Eye Exam _____ Dilated? Yes/No Referred By_____
Primary Vision Coverage _____ Secondary Coverage _____
S.S. # _____ Date: _____

Medical Information

How is your general health? _____
Do you take medications for any of these systems? **(Please circle yes or no.)**

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain _____
Diabetes Yes/No_____ Type _____ Date of diagnosis _____
Allergies to medication Yes/No Which? _____ Reactions? _____
Other health problems _____
Current medication(s)_____
Have you had any operations? Yes/No Kind? _____ When? _____
Name of family doctor and/or primary care physician _____
Date of last visit _____ Date your blood pressure was last checked _____

Family History

High blood pressure	Yes/No	Relation	_____	Macular degeneration	Yes/No	Relation	_____
Diabetes	Yes/No	Relation	_____	Retinal detachment	Yes/No	Relation	_____
Glaucoma	Yes/No	Relation	_____	Cataracts	Yes/No	Relation	_____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind?_____
Have you had any eye operations? Yes/No Type _____ Date _____
Have you had an eye injury? Yes/No Kind _____ Date _____

Do you have glaucoma?	Yes/No	Cataracts?	Yes/No	Dry eyes?	Yes/No
Macular degeneration?	Yes/No	Retinal detachment?	Yes/No	Blurred vision?	Yes/No
Do you wear glasses?	Yes/No	Contact lenses?	Yes/No	Type	_____

Additional information _____

Reviewed by _____ ○ No changes Date _____
Reviewed by _____ ○ No changes Date _____
Reviewed by _____ ○ No changes Date _____

ENTYRE VISION CARE

PATIENT INFORMATION INSURANCE PRIVACY MANAGEMENT DATA

THANK YOU FOR COMPLETEING THIS VERY VALUABLE DATA SHEET.
ACCURACY AND COMPLETENESS IS EXTREMELY IMPORTANT.

NAME: _____

DO WE HAVE PERMISSION TO? (PLEASE CIRCLE ONE)

LEAVE A MESSAGE WITH A MEMBER OF YOUR HOUSEHOLD	YES	NO
LEAVE A MESSAGE ON YOUR ANSWERING MACHINE	YES	NO
LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT	YES	NO
MAIL CORRESPONDENCE TO YOUR HOME	YES	NO

- I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES INCURRED TODAY AND THAT PAYMENT IS EXPECTED AT THE TIME OF SERVICE.
- I ASSIGN ALL INSURANCE BENEFITS FOR PROFESSIONAL SERVICES TO ENTYRE VISION CARE.
- I REALIZE THAT I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE.
- I UNDERSTAND THAT LENSES ARE SPECIAL ORDER AND ARE NOT REFUNDABLE.
- I UNDERSTAND THAT THERE IS A ONE TIME MANUFACTURER REPLACEMENT WARRANTY ON FRAME AND LENSES FOR ONE YEAR FROM DATE OF PURCHASE. (COMPLETE FRAME AND LENSES MUST BE RETURNED)

IF YOUR PRIMARY OR SECONDARY INSURANCE PLAN IS AN HMO OR A MANAGED CARE PLAN IT IS IMPERATIVE THAT YOU PROVIDE US WITH ANY AND ALL PERTINENT INSURANCE INFORMATION INCLUDING ANY CARDS OR CERTIFICATES BEFORE YOU ARE SEEN BY THE DOCTOR.

NOTICE OF PRIVACY PRACTICES

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF AND PROVIDE INDIVIDUALS WITH THIS NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION. IF YOU HAVE ANY OBJECTIONS TO THIS FORM PLEASE ASK TO SPEAK WITH OUR HIPPA COMPLIANCE OFFICER IN PERSON OR BY PHONE AT OUR MAIN PHONE NUMBER.

SIGNATURE BELOW IS ACKNOWLEDGMENT THAT YOU HAVE RECEIVED THIS NOTICE OF PRIVACY PRACTICES.

SIGNATURE:

_____DATE:___/___/___