Old Town Optix Optometry Medical History Form

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: _____ Cell Phone: _____
Guardian (If Applicable Occupation): _____ Email: _____
Birth Date:_____/_____/_____ Age:_____ Race:_____ Occupation: _____

Do you have vision insurance? ☐ No ☐ Yes If yes, insurance carrier? _____
Do you have health insurance? ☐ No ☐ Yes If yes, insurance carrier? _____
If you have medicare/supplemental plan? ☐ No ☐ Yes If yes, insurance carrier? _____

Medical History

List medications you take (including eye drops, aspirin, over-the-counter medications, and home remedies)

_____
_____
_____

Check any of the following that you have had: ☐ Age-related macular degeneration ☐ Inflammatory disorder
☐ Cataracts ☐ Strabismus ☐ Keratoconus ☐ Amblyopia ☐ Glaucoma suspect ☐ Glaucoma
☐ Surgery ☐ Retinal degeneration/Hole/Detachment ☐ Patching ☐ Eye injury

Are you pregnant? ☐ 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, what brand? _____
Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other: Are they comfortable? ☐ Yes ☐ No

Family History

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

Disease/Condition	Yes	No	?	Relationship
Thyroid Disease	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Hypertension	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Strabismus	☐	☐	☐	_____
Amblyopia	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Other	☐	☐	☐	_____

Social History – This information is kept strictly confidential. However, you may discuss this portion directly with the Doctor if you prefer.

☐ Yes, I prefer to discuss my social history information directly with the doctor.

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulties when driving? ☐ No ☐ Yes If yes, please describe:

_____

Do you use tobacco products? ☐ No ☐ Yes If yes, type/amount/how long? _____
Are you a: ☐ Former Smoker ☐ Current Occasional Smoker ☐ Current Everyday Smoker
Do you drink alcohol? ☐ No ☐ Yes If yes, type/amount/how long? _____
Do you use drugs? ☐ No ☐ Yes If yes, type/amount/how long? _____

–OVER–

Name: _____ Date: _____

Review of Systems – Do you currently, or have you ever had, any problems in the following areas:

Eyes	**Yes**	**No**
Itching	☐	☐
Double Vision	☐	☐
Burning	☐	☐
Mattering	☐	☐
Loss of Vision	☐	☐
Red	☐	☐
Floaters	☐	☐
Flashes	☐	☐
Tearing	☐	☐

Other: _____

Constitutional		
Developmental Disorders	☐	☐
Cancer	☐	☐
Fatigue Syndrome	☐	☐

Other: _____

Ear, Nose, Mouth, Throat		
Dry Mouth	☐	☐
Hearing Loss	☐	☐
Laryngitis	☐	☐

Other: _____

Neurology		
Epilepsy	☐	☐
Multiple Sclerosis	☐	☐
Tumor	☐	☐
Cerebral Palsy	☐	☐
Stroke/CVA	☐	☐
Migraine	☐	☐

Other: _____

Psychiatric		
Depression	☐	☐
Bipolar	☐	☐
Anxiety	☐	☐
Attention Deficit	☐	☐

Other: _____

Vascular/Cardiovascular		
Stroke	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Congestive Heart Failure	☐	☐

Other: _____

Respiratory		
Bronchitis	☐	☐
COPD	☐	☐
Emphysema	☐	☐
Asthma	☐	☐

Respiratory (Continued)	**Yes**	**No**
Sleep Apnea	☐	☐

Other: _____

Gastrointestinal		
Celiac Disease	☐	☐
Crohn's Disease	☐	☐
Ulcer	☐	☐
Colitis	☐	☐
Acid Reflux	☐	☐

Other: _____

Genitourinary		
Kidney Disease	☐	☐
STD – Herpetic/Chlamydia	☐	☐
Prostate Disease/ Cancer	☐	☐

Other: _____

Musculoskeletal		
Rheumatoid Arthritis	☐	☐
Ankylosing Spondylitis	☐	☐
Fibromyalgia	☐	☐
Muscular Dystrophy	☐	☐
Gout	☐	☐

Other: _____

Integumentary		
Herpes Simplex/ Cold Sores	☐	☐
Herpes Zoster/Shingles	☐	☐
Rosacea	☐	☐
Psoriasis	☐	☐
Eczema	☐	☐

Other: _____

Endocrine		
Diabetes Type II	☐	☐
Diabetes Type I	☐	☐
Thyroid Dysfunction	☐	☐
Hormonal Dysfunction	☐	☐

Other: _____

Hematologic/Lymphatic		
Anemia	☐	☐
Ulcer	☐	☐
High Cholesterol	☐	☐

Other: _____

Allergic/ Immunologic		
Environmental Allergies	☐	☐
Lupus	☐	☐
Rheumatoid Arthritis	☐	☐
Drug Allergies	☐	☐
Sjogrens Syndrome	☐	☐

Other: _____

If you answered yes to any of the above, or have a condition not listed, please explain:

_____

_____

_____

Signature: _____ Date: _____/_____/_____

Signature on File Form

RESPONSIBILTY STATEMENT

Your insurance is a method for you to receive reimbursement for fees you have paid to the optometrist for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them not with our office. It is your responsibility to pay in advance for the deductible, coinsurance, or any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, however you are responsible for your bill.

FINANCIAL RESPONSIBILTY

By signing this statement you agree to be financially responsible for all charges.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

Patient Signature_____Date_____

Witness_____Date_____

Old Town Optix Optometry

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Old Town Optix Optometry we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give this notice and to follow the terms of this notice. The law permits us to use or to disclose your health information for your normal healthcare operations. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for our normal healthcare operations. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into the computer.

We may share your medical information with our business associates, such as billing services. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointment. If you are not home, we may leave this information on your answering machine or with the person who answers the phone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

We have the right to know of any uses or disclosures we make with your health information as described above normal uses.

As we may need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If your wish to include a statement in your file, please give it to us in writing. We may or may not make changes to your request, however will be happy to include your statement in your file.

If we agree to an amendment or charge, we will not remove nor alter either documents, however will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the department of health and human services, 200 Independence Ave. S.W., RM 509F, Washington, DC 20201. You will not be retaliated against filing a complaint. However, before filling a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at (760)771-0715.

Acknowledgment

I have received a copy of the Old Town Optix Optometry Notice of Privacy Practices.

Date: _____

Signature: _____

Print Name: _____

If signing as a parent or guardian, please note the name of the patient:

_____

WELCOME TO OLD TOWN OPTIX OPTOMETRY!

We would like to take this opportunity to explain a few of our office policies and procedures.

OFFICE HOURS: Monday through Friday, 9-5 and Saturday, 9-4

EMERGENCIES: If during office hours, call and we will get you right in. After hours, you may reach the doctor by calling 909-855-4535. If he doesn't call back within 60 minutes, he may be inaccessible in which case contact another doctor or go to the emergency room.

APPOINTMENTS: Please arrive a few minutes early for your appointment. This time is reserved for you. Please notify us if you have eye care and medical insurance. We will contact you two days in advance of your appointment at the contact number you gave us. If we are unable to speak to you directly we will leave a message requesting you call us to confirm your appointment.
MINORS: If you are not financially responsible for your treatment, the financially responsible person needs to accompany you so once treatment options are discussed, the treatment plan can be approved. This will avoid delays in needed treatment.
PAYMENT FOR SERVICES/INSURANCE: Please come prepared with your eye care and medical insurance information and claim form if used. Remember, it is your responsibility to inform us of any insurance coverage or if it has changed before we provide any services. Be prepared to pay for any co-pays, deductibles or non-plan-covered expenses. For insurance plans where we are not a panel member, you will pay for your services. We will provide you with a "Superbill" which contains all the information required by the insurance company to reimburse you according to your plan benefits. We accept all major credit and debit cards, cash and checks. There is a 1.5% monthly finance charge on any balance we carry. **By signing below, you are authorizing us to accept payment from your insurance company on your behalf (accept assignment). You also acknowledge and understand that you are responsible for all charges not paid or denied by your insurance company.**
PAYMENT PLAN: We will refer you to Care Credit. Depending on your credit and amount financed, you can pay over 6-12 months interest free.
REFUNDS: Eyewear; In order to be eligible for a refund, glasses must be picked up within 14 days of attempted notification. If you are dissatisfied with the sight or fit of your glasses, a full refund will be given up to 14 days after receiving them but only after you see the doctor and give him a chance to make them right. Often a minor correction will solve the problem. We want you to be completely satisfied with your eyewear.
FRAME WARRANTY: All our frames carry a 10 month warranty against manufacturer's defects **under normal use.** If your frame is covered as determined by us, we will repair or replace it at our option one time. If the frame is no longer available from the manufacturer, you will need to purchase new frames and lenses. In this case, we will extend a 25% discount on the new materials. This warranty does not cover lost frames or lenses. Occasionally, your glasses will need to be sent back to the manufacturer for repair or replacement. Be sure to have a spare pair available.

EYEWEAR PRESCRIPTIONS; You are welcome to your glasses or contact lens prescription at any time. Remember most eyeglass prescriptions expire in 1-2 years and contact prescriptions expire yearly.

RETURN VISITS: If you want good sight and eye health your whole life it is important to have regular eye examinations. To help, we proactively schedule your next year's visit today and write it down on your Report of Vision. We will call two weeks in advance to see if the date is still convenient.

We are pleased you have chosen our office for your eye care. We want to be your eye care provider for years to come. Tell us what we can do to help you. Our office continues to grow through your kind referrals and positive social media reviews.

Patient Signature_____ **Date**_____

Original to patient chart_____ **Copy to patient**_____