Medical History Questionnaire

Name of Insurance Policy Holder: _____ **Birth Date:** _____
Relationship to Patient : _____ **SSN #** _____

Patient's Name: _____ GENDER ☐ or ☐ Today's Date: _____ / _____ / _____
Birth Date: _____ / _____ / _____ Social Security # _____ / _____ / _____ CELL Phone: _____
Address: _____ HOME Phone: _____
City: _____ Zip: _____ **Email:** _____
Name of Medical Doctor: _____ Occupation: _____
Dr's Phone: _____ Last Eye Exam: _____

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

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

☐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ☐ NO ☐ YES If yes, do you have visual difficulty when driving? NO ☐ YES ☐ If yes, please describe:

_____

Do you use tobacco products? If yes, type/ amount/ how long: _____

Do you drink alcohol? If yes, type/ amount/ how long: _____

Do you use illegal drugs? If yes, type/ amount/ how long: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems

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

SYSTEM	NO	YES	
CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/ Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
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	☐	☐	☐
Sties 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	☐	☐	☐
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	☐	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

_____

_____

_____ _____

Doctor's Signature Date

HIPAA PRIVACY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, _____ (PLEASE PRINT FULL NAME) (The Patient's Legal Representative), have reviewed the Notice of Privacy of Dr. Joanna Barnett and have been offered a copy of such policy to keep for my records.

Please Initial One:

_____ I hereby acknowledge that I have been provided with a copy of the policy.

_____ I hereby refuse to acknowledge receipt of the Policy. I understand that even though I may refuse to sign the acknowledgement, provider may still provide treatment for me.

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize Dr. Joanna Barnett & Associates to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I request that payment of these benefits be made either to me or on my behalf to Dr. Barnett & Associates for any services and materials furnished as part of my ophthalmological exam.

I authorize any holder of medical information about me to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

_____ _____

Patient Signature *Date*

EYEDOCDULLES - Dr. Joanna Barnett & Associates

Financial Payment Policy

Thank you for choosing Dr. Joanna Barnett & Associates as your vision specialist and eye care provider. We are committed to providing you with the best possible treatment. Please understand that payment of your bill is considered a part of your care.

Regarding Insurance - If you have insurance coverage with one of the insurance plans we participate with, we will bill your insurance company along the guidelines of our contract. As a courtesy to our patients, we will submit all claims directly to the appropriate insurance party. However, we require that **ALL CO-PAYS** be paid at the time of service. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/ or other medical insurance programs. Understand that your selection of insurance coverage is a contract between you and the insurance company. We are not a party to that contract.

If you have an insurance with which we do not participate, we ask that payment be made at the time services are rendered. This may also apply to any auto accident and/or third party injury claim. As a courtesy we will provide the necessary forms to submit your claim independently to your insurance provider or third party representative.

High Deductible Insurance Plans / Co-Insurance / Health Savings Accounts - Many patients now have high deductible insurance plans and/or Health Saving Accounts. These plans typically have $1000 to $3000 insurance deductibles. **All healthcare costs incurred are the patient's responsibility until the deductibles are met.** After the deductibles are reached, your insurance company will begin payment to the provider. **Please be aware, in many instances you will still be responsible for a co-payment, deductible or co-insurance payment per visit**. Dr. Joanna Barnett & Associates will continue to bill your insurance company for services performed. Once we receive an explanation of benefits (EOB) from your insurance company, we will provide you with an itemized statement and require payment for services identified by your insurance company as your responsibility.

Regarding Payment - Payment is due at the time of service. At this time, we accept Cash, Check, Visa, MasterCard, Discover and Health Savings Account cards. **Returned checks will be subject to an additional $25.00 service fee.**

Proof of Insurance - You will be required to show an up to date copy of your insurance card and any necessary referrals at the time of service. If you do not have this information, or we are unable to verify your coverage, you will be required to pay for the services rendered to you that day.

Appointment Cancellation Policy - **PATIENT APPOINTMENT CANCELLATION MUST BE RECEIVED WITHIN 24 HOURS OF SCHEDULED APPOINTMENT TIME.**

A $25.00 Per Patient CHARGE WILL BE ASSESSED FOR NON-CANCELLATIONS, NO SHOW/ MISSED APPOINTMENTS.

I hereby understand the financial policy of this office. I guarantee payment of all charges incurred for the account of the below patient. I further agree to pay any attorney's fee, court costs, and related collection fees incurred.

_____	_____	_____
Patient Name	Responsible Party Signature	Date