CHART #

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Sex: □M □F Age _____ Date_____

Please list any changes to your address or phone number. _____

If this is your first visit, please complete.

Date of last eye exam_____/_____ Location_____

How did you hear of us? □Doctor □Friend □Family Member □Internet □Other:_____

Primary Care Doctor: _____

Pharmacy: _____ **Location:** _____

Are you currently taking: □Flomax □Coumadin □Plavix □Aspirin □Rapaflo □Uroxatra □Minipress □Cardura □Hytrin □Avodart

Current Medications: _____

_____

Allergies to Medications: _____

Check if you have ever had any of the following eye procedures: □LASIK □PRK □RK □Cataract Surgery □Other_____

List all current & previous illnesses, injuries, and surgeries: _____

_____

Please check any of the conditions you have today:

Cardiovascular □chest pain □high blood pressure □irregular/rapid heartbeat □n/a

General □fever □fatigue □ cancer □n/a

Respiratory □asthma □emphysema □shortness of breath □n/a

Genitourinary □trouble urinating □discharge □ulcer □n/a

Musculoskeletal □arthritis □gout □joint or muscle pain □n/a

Psychiatric □anxiety □depression □n/a

Hematologic □anemia □high cholesterol □bleeding disorder □n/a

Ears/Nose/Throat □earache □nasal congestion □pain □n/a

Gastrointestinal □reflux □diarrhea □vomiting □n/a

Integumentary □skin cancer □acne □rosacea □eczema □n/a

Neurological □numbness □memory loss □dizziness □stroke □n/a

Endocrine □diabetes □hypothyroidism □Grave's disease □n/a

Immunologic □allergies □immune disorders □HIV/AIDS □HEP-C □n/a

Other _____

Please check if you or your blood relatives have any of the following conditions. If Yes, check who.

Blindness	□No	□Yes	□Self	□Father	□Mother	□Sibling	□Grandparent
Glaucoma	□No	□Yes	□Self	□Father	□Mother	□Sibling	□Grandparent
Macular Degeneration	□No	□Yes	□Self	□Father	□Mother	□Sibling	□Grandparent
Diabetes	□No	□Yes	□Self	□Father	□Mother	□Sibling	□Grandparent
Retinal Detachment	□No	□Yes	□Self	□Father	□Mother	□Sibling	□Grandparent

Social History

Do you currently drive? □No □Yes

Do you currently smoke? □No □Yes How Much? □ Less than 1 pack a day □ 1 pack a day □ More than 1 pack a day

Have you ever smoked? □No □Yes When did you quit? _____

Are you pregnant? □No □Yes Anticipated due date? _____

Are you working? □No □Yes □Retired

Doctor's Signature_____ **Date** _____

DATE	PATIENT INFORMATION	PATIENT NUMBER
_____		_____

NAME _____

ADDRESS_____

CITY _____

STATE _____ ZIP CODE _____

PHONE # ( ) _____

CELL # ( ) _____

EMAIL _____

SOCIAL SECURITY # _____

DATE OF BIRTH _____

AGE _____ GENDER Male Female

MARITAL STATUS Single Married Widowed Divorced

SPOUSE'S NAME _____

EMERGENCY PHONE # ( ) _____

RELATIONSHIP _____

RESPONSIBLE PARTY

NAME _____

RELATIONSHIP _____

ADDRESS _____

EMPLOYER_____

SOCIAL SECURITY # _____

DATE OF BIRTH _____

PHONE # ( )_____

CELL # ( )_____

Consent for Services and Disclosure of Protected Health Information For Payment, Treatment and Health Care Operations

- I authorize and consent to the professional services rendered to the above patient. Authorization is given to release information as may be necessary for the completion of medical insurance claims, the benefits of which may be assigned to the physician at his option.
- I agree to pay interest on any uncollected amount of debt to ***Bay Eyes Cataract & Laser Center, P. C***. & ***Bay Eyes Surgery Center d/b/a VisionaryUSA.com Surgery Institute***. I agree to pay the cost of collection for past due debt. I acknowledge responsibility for the payment of services rendered, and agree to pay for them at the time of service. Co-pays, fitting fees and refractions not covered by insurance will be paid at the time of service.
- By signing below, you hereby consent for this practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose of treatment, payment and healthcare operations. You may refuse to share your information.
- You should read the Notice of Privacy Policies for PHI located at the front desk or the lobby copy provided at the doctor's office before you sign the consent form. If you would like a personal copy, please ask the front desk receptionist. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer of this practice.
- You have the right to request that this practice restrict how PHI is used or disclosed to carry out treatment, payment or health care operations. This practice is not required to agree to requested restrictions; however, if the practice does agree to your requested restrictions, the restriction is binding on it.
- Information about you is protected under federal law, and you have the right to revoke this consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to the consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.
- You may communicate with the following individual (s) regarding my condition or course of treatment (s): _____

  _____
- You may communicate confidential information to me at the address and phone numbers listed above or at the following: _____

  _____
- **Signed** _____ **Date**_____

BAY EYES CATARACT AND LASER CENTER

FINANCIAL POLICY

Thank you for choosing our office to provide your eye care. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding, and to better serve you, we ask that all patients read and sign our Financial Policy. If you have any questions, please ask.

1. **VERIFYING INSURANCE:** As a courtesy to our patients, we will verify insurance for eligibility benefits prior to the first appointment, as well as any time we are notified of a change in coverage. The insurance companies do not guarantee payment based on the information that they provide us. You are ultimately responsible for knowing if there are any waiting periods for work to be performed. Any amount on your treatment plan that is not covered by your insurance is your financial responsibility.
2. **INSURANCE INFORMATION:** New insurance, as well as changes in insurance, must be provided to our office prior to your appointment. Accepting assignment of benefit from your insurance company is the equivalent of extending your credit; therefore we must have your Social Security Number on file. If you choose not to provide us with your Social Security Number, you will be responsible for payment in full at the time services are rendered.
3. **CHANGES IN PERSONAL INFORMATION:** Changes in your address or telephone numbers should be provided to us immediately. If this office is unable to contact you by telephone or mail and your balance is overdue, your account will be sent to a collection agency.
4. **REQUESTS FOR ADDITIONAL INFORMATION:** These must be responded to immediately. Such requests include proof of a college student's full-time status and proof of continued enrollment in any insurance plan. Failure to provide this information to the insurance company in a timely manner may result in the entire balance being your responsibility.
5. **PAYMENT:** Payment is due at the time of service. Additionally, if you have a balance following a previous visit, you will be expected to pay that amount as well. If payment is made directly to you for services billed by Bay Eyes, you agree to promptly remit payment to Bay Eyes.
6. **PAYMENT PLANS:** In addition to cash, checks, Visa, MasterCard, and Discover, we offer several payment plans—please see our staff for details.
7. **REFUNDS:** Overpayments will be refunded to the appropriate party, normally the insurance company or the guarantor. Patients' refunds will not be processed until all active or past due accounts and insurance claims have been paid in full. Any balances of $25 or less will remain on account for ninety (90) days, and if not used will be adjusted off the account.
8. **RETURNED CHECKS:** There will be a $30 fee for all returned checks. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash, or credit card. Once a check has been returned, this office will no longer accept personal checks for payment.

Patient or Guardian Signature_____ **Date** _____

Printed Name of Patient or Guardian _____