IDEAL EYECARE

PATIENT HEALTH HISTORY

Last Name:_____ First Name:_____

Date of Birth:_____ Sex: M/F Nickname/Preferred Name:_____

Address:_____

City:_____ State:_____ ZIP:_____

Preferred Telephone #_____Home Work Cell (Used for appt reminders)

In Case of Emergency & Phone #:_____

How did you hear about our office/Ideal Eyecare?_____

Employer:_____ Occupation:_____

Hobbies:_____ Email:_____

Account Responsible/Subscriber Information (if different from above)

Last Name:_____ First Name:_____

Date of Birth:_____ SSN:_____-_____-_____ Sex: M / F

Address:_____

City:_____ State:_____ ZIP:_____

Preferred Telephone#_____Home Work Cell Used for appointment reminders

Employer:_____ Policy #_____

Name of Medical Insurance _____

Name of Vision Insurance _____

HIPAA Patient Consent Form

Our Notice of Privacy Practices describes how we may use/disclose protected health information (PHI). You have the right to restrict how your protected health information is used/disclosed for treatment, payment, or healthcare operations. HIPAA (Health Insurance Portability and Accountability Act of 1996) Law allows for the use of this information for treatment, payment, or healthcare operations. By signing this form, you consent to our use of your PHI for treatment, payment, or healthcare operations. We may change the privacy policy as allowed by law. You may revoke this consent in writing at any time, at which point all full disclosures will cease but not be retroactive. Your signature also consents sending appointment reminders/confirmations by phone, email, or text message.

My signature indicates my understanding and consent: _____

Patient/Guardian Signature: I give my permission to **Ideal Eyecare** to release information about my medical and or financial to the following person(s) or medical doctor(s) listed here:

Name: _____ Phone: _____

Name: _____ Phone: _____

NOTE: To all insurance patients: The procedures performed in this office are medical in nature. Professional fees will be submitted to your vision and/or medical insurance. Patients will be billed for any un-met deductibles, co-insurance, or copays. I authorize payment of insurance benefits to **MRT Optometry PC**. I agree to be financially responsible for any balance not paid by my insurance plan. I understand professional fees are non-refundable. I authorize the release of information including diagnosis and records of treatment or examination rendered to me or my dependents during the period of such care to third party payers, billers/collections and/or health practitioners.

Patient/Guardian Signature _____

PERSONAL MEDICAL HISTORY: Please check if any of the following applies to YOU, and list any medications for each condition that you check. If you do not have any of these conditions, please check NONE.

Allergic/Immunologic: ___None ___HIV/AIDS ___Rheumatoid Arthritis ___Lupus ___Neurofibromatosis ___Other:	Cardiovascular: ___None ___Hypertension ___Stroke ___Heart Disease ___Vascular Disease ___Other:	Constitutional: ___None ___Cancer ___Trauma/Large Volume Blood Loss ___Developmental Disability ___Other:
Ear/Nose/Throat: ___None ___Hearing Loss ___Upper Respiratory Infection ___Other:	Endocrine: ___None ___Non-insulin Dependent Diabetes ___Insulin Dependent Diabetes ___Thyroid Dysfunction ___Hormonal Dysfunction ___Other:	Gastrointestinal: ___None ___Crohn's ___Colitits ___Other:
Genitourinary: ___None ___Bladder Dysfunction ___Kidney Dysfunction	Hematologic: ___None ___Anemia ___Leukemia ___Other:	Integumentary: ___None ___Eczema ___Rosacea ___Psoriasis ___Other:
Musculoskeletal: ___None ___Osteotarthritis ___Fibromyalgia ___Muscular Dystrophy ___Ankylosing Spondylitis ___Other:	Neurological: ___None ___Multiple Sclerosis ___Epilepsy ___Cerebral Palsy ___Tumor ___Other:	Psychiatric: ___None ___ADHD ___Depression ___Schizophrenia ___Other
Respiratory: ___None ___Asthma ___Bronchitis ___Emphysema ___COPD ___Other:	Pregnant: Y / N Nursing: Y / N Alcohol Use: Y / N Amount: Tobacco Use: Y /N Amount:	

Please list any medications that you are currently taking (including herbal or over the counter). Or attach a LIST

1._____ For_____ 5._____ For_____
2._____ For_____ 6._____ For_____
3._____ For_____ 7._____ For_____
4._____ For_____ 8._____ For_____

Do you have any allergies to medication? □No □Yes If yes, please list:

_____

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

_____

Eye Health History-Do you (patient) experience any of the following?

Blurred Vision	N	Y
Flashing lights	N	Y
Dizziness	N	Y
Distorted Vision	N	Y
Painful Eyes	N	Y
Red Eyes	N	Y
Double Vision	N	Y
Watery Eyes	N	Y
Itchy Eyes	N	Y
Burning Eyes	N	Y
Aching Eyes	N	Y
Floaters	N	Y
Lose Place When Reading	N	Y
Light Sensitivity	N	Y
Discharge	N	Y

Family Ocular History-Has anyone in the patient's family (blood relative) had any of the following?

Cataracts	N	Y
Glaucoma	N	Y
Diabetes	N	Y
Cornea Disease	N	Y
Macular Degeneration	N	Y
Cancer	N	Y
Crossed Eyes	N	Y
Heart Disease	N	Y
Lazy Eye	N	Y
Retina Disease	N	Y
High Blood Pressure	N	Y

Other:_____