LOMAN EYE CARE

Patient History Questionnaire

First Name _____ Last _____ MI _____ DOB ____/____/____

Nickname/Preferred name/Pronouns _____ Sex □ M □ F SS# _____-_____-_____

Address _____ City _____ Zip Code_____

Telephone (Cell)_____ (Work)_____(Home)_____

Email Address_____

Occupation/ job title _____ Employer_____

Emergency contact _____ Phone# _____ Rel. to patient _____

Date of last eye exam_____ Doctor/Location_____

How did you hear about us / Referred by _____

Name of **Medical** Insurance (ex Anthem, Cigna, Medicare) _____

Name of Insured (person who carries the insurance) _____

Insured's SS# _____-_____-_____ Insured's D.O.B. _____/_____/_____

Insured's Phone# _____ Insured's Relationship to patient_____

Name of **Vision Plan** (ex. VSP, EyeMed) _____

Name of Insured (person who carries the insurance) _____

Insured's SS# _____-_____-_____ Insured's D.O.B. _____/_____/_____

Insured's Phone# _____ Insured's Relationship to patient_____

Name of **Responsible Party (**if other than self) _____ DOB _____

Relationship to patient _____ Ph# _____Address (if different)_____

By signing, I signify that the above information is true and that Loman Eye Care is not responsible for incorrect or incomplete information affecting the billing to and subsequent payment by my insurance company or vision plan and that I am responsible for any balance on my account after the billing of my insurance (in network).

Signature:_____ **Date:** _____/_____/_____

Do you currently wear glasses? □ No □ Yes - How old are your present glasses?_____

Do you wear contact lenses? □ No □ Yes – brand_____

Right Eye: B.C.____ power: _____ Left: B.C.____ pwr_____

Are you interested in laser vision correction? (LASIK, PRK etc) □ No □ Yes

Have YOU ever been diagnosed with:

Glaucoma: □ No □ Yes Macular degeneration: □ No □ Yes Dry Eye: □ No □ Yes
Retinal Detachment: □ No □ Yes Amblyopia (lazy eye): □ No □ Yes Cataracts: □ No □ Yes

Any eye operations or injuries? If Yes, type _____**Date**____/_____/____

Any other eye problems? Please explain_____

Do you have problems with: (if yes, please circle or write in)

□ No □ Yes Cardiovascular- *heart disease, high blood pressure, other*_____
□ No □ Yes Endocrine- *diabetes, thyroid, other*_____
□ No □ Yes Genital, Kidney and Bladder- *infections, other*_____
□ No □ Yes Ear, Nose and Throat- *sinus, hearing loss, other*_____
□ No □ Yes Psychiatric- *anxiety, depression, ADHD, other*_____
□ No □ Yes Musculoskeletal- *arthritis, back pain, RA, other*_____
□ No □ Yes Skin- *rosacea, skin cancer, psoriasis, other*_____
□ No □ Yes Respiratory- *asthma, COPD, other*_____
□ No □ Yes Gastrointestinal- *ulcers, reflux, other*_____
□ No □ Yes Blood/Lymph- *elevated cholesterol, anemia, other*_____
□ No □ Yes Neurological- *migraines, MS, stroke, seizures, other*_____

Are you Diabetic? If Yes, last A1C _____ Date of testing _____ Doctor _____

Please list any other health condition _____
_____

MEDICATIONS you are taking: _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Are you **ALLERGIC** to any Medications? □ No □ Yes _____

Name of Family Doctor _____ Location/phone _____

Do you use: Cigarettes/Tobacco: □ No □ Yes □ Quit, former user of: _____

Alcohol: □ No □ Yes, how often:_____ Other substances: □ No □ Yes,_____

What Hobbies/ sports /activities do you participate in? _____

Do you wear eyeglasses, contact lenses or RX sunglasses for this? □ No □ Yes,_____

Do you spend time on a computer or screen? If yes, how many hours per day? _____ hrs / day at □ Home □ Office

Do you have computer glasses? □ No □ Yes

Do you have blue light blocking glasses? □ No □ Yes

Does anyone in your FAMILY have a history of:

□ High blood pressure, who _____ □ Macular Degeneration , who _____

□ Diabetes, who _____ □ Retinal Detachment, who _____

□ Cataracts, who _____ □ Glaucoma, who _____

□ Other: Blindness/Vision Loss etc: _____, who _____

Is there any other information you would like the doctor to know regarding your personal ocular, medical or family history?

If yes. Please explain:

_____

_____

Authorization To Release Information for Insurance Filing

I authorize the release of my information to my insurance carriers, including Medicare, for information required to file or resubmit my claim. I further authorize my insurance companies to pay Loman Eye Care directly on my behalf. I further authorize all insurance companies including Medicare Supplement to provide any information to Loman Eye Care that is required to resubmit any denied or incorrectly paid insurance claims. This authorization remains in effect until withdrawn by me.

Acknowledgment of Receipt

I acknowledge that I have been offered or received a copy of Loman Eye Care's Notice of Privacy Practices.

Signature:_____ **Date:** _____/_____/_____

Authorization to Discuss Your Information with Family or Caregivers

To comply with the new HIPAA Federal Privacy Regulations, we must receive your written approval to discuss your case with anyone else including family, children, caregivers, etc… By authorizing this, we will be able to, without requiring your presence, discuss your case, answer questions, leave detailed messages, and contact, in the event of an emergency, the person(s) listed below.

If you would like us to answer questions or discuss your case with anyone other than yourself, you must include them below. This authorization is optional and can be withdrawn at any time by you.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Signature:_____ **Date:** _____/_____/_____

Loman Eye Care
630 3rd Ave S.W. Suite 100
Carmel, IN 46032
Phone: 317-844-7474
Fax: 317-819-0073

Please Release My Eyecare Information From:

Patient Name: _____

Patient DOB: _____

Name of Practice: _____

Address of Practice:

_____

City, State, Zip: _____

Phone Number: (_____)_____
Fax Number: (_____)_____

Information To Be Released

- ❑ The Most recent 2 Years of pertinent information (charts notes and special tests)
- ❑ All Medical Records
- ❑ Specific Information (please specify)

Purpose For Which Disclosure is Being Made:

- ❑ Sharing with other healthcare providers
- ❑ Legal Investigation
- ❑ I am transferring my care to another provider
- ❑ Personal Use
- ❑ Other:

_____

My Rights

I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice posted at the facility where the information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature:_____ **Date:** _____/_____/_____