LOMAN EYE CARE

Patient History Questionnaire

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

Nickname / Preferred name _____ 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 of Patient (responsible party): _____Date____/____/___

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

Do you wear contact lenses? □ No □ Yes – brand_____ Rt pwr_____Lt pwr_____

If No, are you interested in wearing contacts at this time? □ No □ Yes

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 currently 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:

_____

_____

Sign and date: _____ Date_____/_____/_____

LOMAN
EYE CARE

Digital Retinal Imaging

Loman Eye Care is committed to providing our patients the most thorough eye health Examination possible. We are pleased that we are able to perform Digital Retinal Imaging using a non-mydriatic (no dilation needed) retinal camera that can aid the doctors in early detection of ocular diseases & abnormalities (ex. Glaucoma, macular degeneration, diabetes, etc)

**If you have a history or family history of high blood pressure, diabetes, glaucoma or macular degeneration the doctors urge you to take advantage of this technology. Age 5+

The cost is $35.00 (Screenings are not covered by most insurances)

Please indicate below:

_____ **Yes,** I want to receive the Digital Retinal Imaging

_____ **No,** I do not want to receive the Digital Retinal Imaging and acknowledge that this painless and non-invasive test is the best way to detect and monitor subtle changes in my eye health on an on-going basis.

Should you have any questions, please feel free to consult with the doctor.

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:_____

X Signature:_____ Date:_____

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.

X Signature:_____ Date:_____

Acknowledgment of Receipt

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

X Signature:_____ Date:_____