Murray Family EYECARE

PATIENT QUESTIONNAIRE

(Completion required at each appointment)

First Name _____ Middle Name _____ Last Name _____

Name you wish to be called _____ SSN ___XXX – XX – XXXX___ M or F

Birth Date ___MM – DD – YYYY___ Age _____ Marital Status: Single Married Widowed Divorced

Legal Guardian _____ Relationship _____

Home Address _____ City _____ State _____ Zip _____

Employer / School _____ Occupation _____

(Please mark preferred)

☐ Cell (_____) _____- _____

☐ Home (_____) _____- _____

☐ Work (_____) _____- _____

Would you like to receive text messages to remind you of upcoming appointments?

☐ Yes ☐ No

Email? ☐ Yes ☐ No

Email Address:

_____

Our office will file all vision claims if we are a participating provider for your plan.
Please provide office staff with all current insurance cards. A copy must be kept on file. Thank you.

Primary Vision Insurance

☐ None

Policyholder's relationship to patient: *(circle one)* Self Spouse / Partner Parent / Guardian Other _____

If self, there is no need to repeat information given above.

Policyholder ___FIRST___MIDDLE___LAST___ Policyholder's Birth Date ___MM – DD – YYYY___

Home Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone (_____) _____- _____

Name of Insurance _____ ID # / SSN ___XXX – XX – XXXX___

Policy Number _____ Group Number _____

Primary Medical Insurance

☐ None

Policyholder's relationship to patient: *(circle one)* Self Spouse / Partner Parent / Guardian Other _____

If self, there is no need to repeat information given above.

Policyholder ___FIRST___MIDDLE___LAST___ Policyholder's Birth Date ___MM – DD – YYYY___

Home Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone (_____) _____- _____

Name of Insurance _____ ID # / SSN ___XXX – XX – XXXX___

Policy Number _____ Group Number _____

Patient Lifestyle

Our goal is to provide our patients with quality eyewear that will meet all of their lifestyle needs. Over the years, there have been major advances in frame and lens technologies. With these advances, we are given the opportunity to better assist our patients in purchasing eyewear that will perform to their expectations yet be comfortable and stylish.
In helping us ensure that the eyewear you receive will enable you to successfully perform all of your daily activities, whether it be for work or play, we request that you fill out this brief questionnaire. This information will allow us to better assist you in making the eyewear choices most beneficial to your lifestyle.

Do you wear? ☐ Glasses ☐ Contact Lenses ☐ Both ☐ Neither

If you wear glasses, when do you wear them? (Check all that apply)

☐ Driving ☐ Computer use ☐ Driving at night only ☐ Watching TV ☐ Other _____

☐ Reading ☐ Sports or outdoor activities ☐ Doing fine point work or hobbies _____

Do you have sunwear? ☐ Yes ☐ No **Are they prescription?** ☐ Yes ☐ No

Have you ever been bothered by any of the following:

☐ Glare from oncoming headlights ☐ Glare from the sun

☐ Headaches during or after working at the computer ☐ Overhead lighting at work or home

☐ Dry, tired, or sore eyes ☐ Unable to read small text on a cell phone

☐ Scratches on lenses ☐ Comfort or weight of glasses

☐ Allergic reaction to frame or nosepads

Does your occupation require any of the following? (Check all that apply)

☐ Working around chemicals or in an industrial environment ☐ Safety eyewear

☐ Driving more than 6-8 hours a day ☐ Computer use for 6-8 hours a day

On a scale of 1 to 5 (1 being most important), rate how important each of the following is to you in selecting your eyewear.

_____Styles and trends _____Price _____Quality and durability

_____Cost _____Comfort

Do you plan to replace your current eyewear today? ☐ Yes ☐ No

Are you interested in Laser Vision Correction? ☐ Yes ☐ No

Are you interested in wearing contact lenses? ☐ Yes ☐ No

If you wear contact lenses, when do you wear them? ☐ All the time ☐ Occasionally

Do you have backup (up-to-date) glasses that you are not embarrassed to wear when not wearing contact lenses? ☐ Yes ☐ No

What do you want to change about your present contact lenses?

_____

Would you like to be able to enhance or change your eye color? ☐ Yes ☐ No

Medical History / Review of Symptoms

Many medical conditions and medications affect the eyes. Please help the doctor by filling out your medical history as completely as possible.

Date of last eye exam _____ Name of Doctor _____

Are you currently having eye or vision problems? ☐ Yes ☐ No

If yes, please explain _____

Do you use tobacco products? ☐ No ☐ Yes Please explain _____

Do you drink alcohol? ☐ No ☐ Yes How often? _____

Do you use illegal drugs? ☐ No ☐ Yes Please explain _____

List any medications you are now taking, including hormones, birth control, aspirin, eye drops and antihistamines. _____

_____

_____

Are you allergic to any medications? ☐ No ☐ Yes Please list _____

_____

Are you pregnant? ☐ No ☐ Yes

Health History: Do you or a family member (mother, father, grandparents, siblings) have or ever had any of the following health conditions:

You	Family		You	Family	
☐	☐	AIDS / HIV	☐	☐	High Blood Pressure
☐	☐	Allergies	☐	☐	High Cholesterol
☐	☐	Anxiety	☐	☐	Kidney Disease
☐	☐	Arthritis	☐	☐	Lupus
☐	☐	Artificial Heart Valve	☐	☐	Multiple Sclerosis
☐	☐	Asthma	☐	☐	Osteoporosis
☐	☐	Bleeding	☐	☐	Pacemaker
☐	☐	Cancer	☐	☐	Retinal Disease
☐	☐	Depression	☐	☐	Rheumatic Fever
☐	☐	Diabetes	☐	☐	Shingles
☐	☐	Emphysema	☐	☐	Sickle Cell
☐	☐	Epilepsy	☐	☐	Sinus Problems
☐	☐	Fainting / Black Outs	☐	☐	Skin Conditions
☐	☐	Heart Condition	☐	☐	Stroke
☐	☐	Heartburn	☐	☐	Thyroid Disorder
☐	☐	Hepatitis (type_____)	☐	☐	Tuberculosis

Eye History: Do you have or have ever had any of the following conditions:

☐ Blurred Vision	☐ Dizzy Spells	☐ Headaches	☐ Itchy, burning watering eyes
☐ Cataracts	☐ Eye Strain	☐ Halos	☐ Migraines
☐ Dry Eye Syndrome	☐ Eye Injury	☐ Lazy / Crossed Eyes	☐ Poor Color Vision
☐ Double Vision	☐ Eye Infection	☐ Light Sensitivity	☐ Retinal Detachment
☐ Discharge from Eyes	☐ Eye Surgery	☐ Loss of Vision	☐ Turned Eye
	☐ Flashes / Floaters	☐ Macular Degeneration	
	☐ Glaucoma		

Are you currently being treated for any medical condition not listed above? ☐ Yes ☐ No

If yes, what? _____

Informed Consent and Financial Responsibility

Murray Family Eyecare prescribes high quality contact lenses to improve your vision and lifestyle. Contact lenses are FDA regulated medical devices that can cause discomfort, infections and permanent vision loss if not cared for properly. New and existing lens wearers require additional time and testing during an eye examination to minimize risk of serious eye problems. The additional testing is only done for contact lens wearers. For this reason, there are additional evaluation and service fees for new and existing contact lens wearers.

Dilation of the pupils is necessary in order to fully evaluate the health of your eyes. In fact, dilation is absolutely required to fully examine the interior of the eye because without it only 30% of the retina can be seen. Therefore, many diseases and potentially sight-threatening conditions will not be diagnosed unless this procedure is done. The main side effects are blurry near vision and an increased sensitivity to bright lights. The procedure is painless and the effects last approximately 2-4 hours. Most, but not all, patients are still able to drive while their eyes are dilated. We strongly recommend having this done so that we may fully assess the health of your eyes. There is no additional charge for this procedure.

☐ YES, I agree to have my pupils dilated.

☐ NO, I do not consent to having my pupils dilated.

I assume responsibility for scheduling an appointment if I decide to have my eyes dilated at a later date.

Payment for all services and procedures is the responsibility of the patient.
I agree to pay for all co-pays, deductibles, co-insurances and non-covered services as determined by my insurance company.
I understand that a returned check fee is applied to every returned check.
I agree to pay an additional collection fee for all accounts not paid in the time stated on the final monthly statement.
I authorize the release of medical information concerning my illness and treatment by Murray Family Eyecare to my insurance company. I also authorize release of my personal medical information to any doctor whom I may be referred to.
I understand eligibility and verification of benefits is NOT a guarantee of payment as stated by my insurance company.
I authorize payment of my insurance benefits to Murray Family Eyecare.

I acknowledge that the HIPAA Notice of Privacy Practices was both clearly displayed and available to read during my office visit.

By signing below you agree that you have read and understand the statement of Informed Consent and Financial Responsibility.

_____ _____

Patient or Legal Guardian Today's Date

Lake Printers, Inc.