Medical History Questionnaire

Name: ______________________________ Today's Date: ______ / ______ / ______
Address: ______________________________ Home Phone: ______________________
______________________________ Work Phone: ______________________
Email: ______________________________ Cell Phone: ______________________
Birth Date: _____ / _____ / _____ Social Security #: _____ / _____ / _____ Last Eye Exam: _____ / _____ / _____
❒ Male ❒ Female Name of Medical Doctor: ______________________ Dr.'s Phone: ______________________
Preferred Language: ______________________________ Last Medical Exam: _____ / _____ / _____

Race: ❒ American Indian or Alaskan Native ❒ Asian ❒ Black or African American ❒ Decline to Specify ❒ Hispanic ❒ Native Hawaiian or Other Pacific Islander ❒ White

Ethnicity: ❒ Declined to Specify ❒ Hispanic or Latino ❒ Native Hawaiian/Other Pacific Islander ❒ Not Hispanic or Latino

Communication Preference: ❒ Text ❒ Email ❒ Postal ❒ Telephone

Medical History

Do you have any allergies to medications? ❒ no ❒ yes If yes, explain: ______________________________
____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies).
____
____
____

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

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury ______________________________

Are you pregnant and/or nursing? ❒ no ❒ yes
Do you wear glasses? ❒ no ❒ yes If yes, how old is your present pair of lenses? ______________
Do you wear contact lenses? ❒ no ❒ yes If yes, how old is your present pair of lenses? ______________
Type of contact lenses: ❒ Rigid ❒ Soft ❒ Extended Wear ❒ Other Are they comfortable? ❒ yes ❒ no
If you don't wear contact lenses, are you interested in trying them? ❒ yes ❒ no

Family History

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	❒	❒	❒	______________
Cataract	❒	❒	❒	______________
Crossed Eyes	❒	❒	❒	______________
Glaucoma	❒	❒	❒	______________
Macular Degeneration	❒	❒	❒	______________
Retinal Detachment/Disease	❒	❒	❒	______________
Arthritis	❒	❒	❒	______________
Cancer	❒	❒	❒	______________
Diabetes	❒	❒	❒	______________
Heart Disease	❒	❒	❒	______________
High Blood Pressure	❒	❒	❒	______________
Kidney Disease	❒	❒	❒	______________
Lupus	❒	❒	❒	______________
Thyroid Disease	❒	❒	❒	______________
Other ______________	❒	❒	❒	______________

** Please turn this form over and complete side two **

Do you drive? ☐ no ☐ yes If yes, do you have visual difficulty when driving? ☐ no ☐ yes If yes, please describe:

____

Do you use tobacco products? ☐ no ☐ yes If yes, type/amount/how long: ______________________

Do you drink alcohol? ☐ no ☐ yes If yes, type/amount/how long: ______________________

Do you use illegal drugs? ☐ no ☐ yes If yes, type/amount/how long: ______________________

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐

SYSTEM	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR / CARDIOVASCULAR			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC / HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

____

____

____

____

____

______________________________________ ______________________

Doctor's Signature Date

A1A FAMILY EYECARE

Privacy Acknowledgement Form

Name: ____ Today's Date: _____/_____/_____
Last First MI

Sex: ❑ M ❑ F Marital Status: ________ DL# ____________________ State Issued ______

If Student: Grade _____ School ____________________ Parent's Name (If Minor) ____________________

Employer: ____________________ Address: ______________________________

Names of children living with you: ____________________ Hobbies: ____________________

Responsible party for account: ____________________ Phone: ____________________

Do you have insurance? ❑ No ❑ Yes Responsible party DOB:________ Email:____________________

If yes: **Insurance Provider:** ____________________ **Insurance ID#:** ____________________

Primary Insured's Name:____________________ **DOB:** ____________________

Who may we thank for referring you to this office? ______________________________

- All professional services, which includes eye examinations and office visits must be PAID IN FULL when services are rendered.
- All materials, such as glasses and contact lenses must be PAID IN FULL before orders are placed.
- Any balance incurred as a result of not having a required referral or correct insurance information will be your responsibility.
- If your claim is denied for any reason or we have not received payment within 4-6 weeks from filing, you are responsible for the balance due within 30 days.
- We do not accept personal checks.

MEDICARE-LIFETIME AUTHORIZATION

I request payment of authorized Medicare benefits or other insurance benefits be made to either me or on my behalf to Dr. Horning for any services furnished to me by Dr. Horning. I authorize any holder of my medical information to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

By signing below, I acknowledge that I have read and agree to all of the above information:

Patient/Guardian Signature: ______________________________ Date:____________________

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

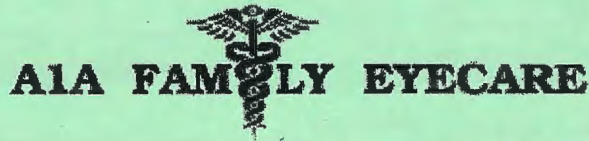
I, ________________________, have reviewed/received a copy of A1A Family Eyecare's Notice of Privacy Practices.
Patient Name

Patient/Guardian Signature: ______________________________ Date:____________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:



Authorization to Release Information

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give consent to release this information to the family members indicated below. This consent form will not allow *A1A Family Eyecare* to release any other information to these family members. This authorization shall be in force and effect for the duration of 60 months, at which time this authorization will expire. You have the right to revoke this consent in writing.

I ______________________ authorize/allow *A1A Family Eyecare* to release my medical and/or billing information to the following individual(s):

1.______________________________Relation to Patient: _________________

2.______________________________Relation to Patient: _________________

3.______________________________Relation to Patient: _________________

Signature:__________________________ Date:______________

A1A FAMILY EYECARE

Dilation Release Form

The Florida Board of Optometry has adopted regulation 59-V3.010 that requires all patients to have dilation upon their initial examination. If you have not previously been dilated under our care then we would be required to perform the procedure.

Dilation of the eye expands the pupil and allows a more thorough examination of the retina than would be possible without the procedure.

These are a few things you should be aware of concerning dilation:

- Dilation will enlarge your pupils, which will decrease your ability to see reading distance.
- Dilation may make it difficult to see at a distance and allow sunlight to be very uncomfortable.
- Driving a vehicle may be difficult after dilation.
- If you elect to have the procedure, it will be an additional 30-45 minutes to do the examination, allowing sufficient time for the dilation drops to take effect.
- The effect of the dilation will last 4 to 6 hours.

OPTOMAP RETINAL EXAM

We are pleased to be able to offer our patients the Optomap Retinal Exam which allows our doctors to review an ultra-wide view of the retina (back of the eye). This evaluation can lead to the early detection of many eye diseases like glaucoma, macular degeneration, and retinal detachment. This technology can also detect systemic disorders such as diabetes, high blood pressure, cholesterol, and even cancer. This exam is painless, quick, and, in MANY cases, does NOT require dilating drops. Since this test is not yet covered by most insurance plans, there will be a small fee of $39.00 for this test.

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS, after reading and understanding all aspects of the dilation procedure.

______ I understand the above and elect to have my eyes dilated.

______ I understand the above and elect NOT to have my eyes dilated.

______ I understand the above and elect to have the retinal exam from Optomap.

Patient Signature ______________________________ Date: ____________________

Insurance and billing in regards to HMO plans

A1A Family Eyecare does not participate with all health maintenance organizations (HMOs). In addition, an HMO will not typically pay for services without prior authorization from your insurance company. Your physician's referral alone does not necessarily constitute an authorization from your HMO.

A1A Family Eyecare requests a deposit for all unauthorized services. Deposits are based on an estimate of the cost of services you or your physician request and are not necessarily payment in full. Your actual charges may be greater or less than the deposit. If further testing or consultations are necessary, additional deposits may be required. If actual charges are less, the balance of the deposit will be refunded.

If insurance authorization for your services can be verified with your HMO prior to services being rendered, you will not be required to make a deposit for the authorized services. However, if additional services are necessary, further authorization or deposits will be required. Further authorizations may take a week or longer, depending on the necessity of review by the HMO's medical director or review committee. We will assist by filing insurance claims as services are incurred.

Please sign to acknowledge that you have read and understand this policy. Thank you!

x.________________________________ Date.____________

Medicare Guidelines

GENERAL RULES

The patient must pay an annual deductible toward any qualified health care before Medicare will pay for any services. After the deductible has been met for the year, Medicare will pay 80% of their "approved fee" and the patient pays 20% as a copayment plus any noncovered fees.

If you have supplemental insurance, it may cover the cost of the deductible and copayment. If your supplemental insurance is an approved "Medigap" policy, Medicare will automatically file your supplemental insurance claim for you. Not all supplemental policies are "Medigap" policies. You may be required to file a secondary insurance claim after you have received your Explanation of Benefits from Medicare.

Our Office will file your insurance claim for Medicare and accept payment directly from them if the services qualify for Medicare coverage (see exceptions below). Any charges Medicare will not cover are payable by the patient at each visit.

SPECIAL EXCEPTIONS

1. Medicare does NOT cover the refraction portion of an eye exam. The refraction determines the eyeglass or contact lens prescription. **The cost of this non-covered service is $39.00.** Payment is due at the time the services are rendered.
2. Medicare does NOT cover any services unless the doctor makes a medical diagnosis. If your only diagnosis is myopia, hyperopia, astigmatism or presbyopia, Medicare will not pay for any services.
3. Medicare may deny benefits if they feel you are receiving examinations too frequently, or are receiving exams by more than one doctor for the same illness.
4. Your signature on this form will serve as your "Signature on File" for processing Medicare forms.

Patient Name__________________________ Medicare ID#_____________________ Date of Birth___/___/___

Supplemental Insurance Name______________________ ID#_______________________ Group#____________

I HAVE READ AND UNDERSTAND THE ABOVE AND I AGREE TO PAY FOR SERVICES AND MATERIALS THAT MEDICARE DOES NOT COVER. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIANS OR SUPPLIER FOR SERVICES. ADDITIONALLY, I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

Patient Signature________________________________ Date___/___/___

ROWE FAMILY EY[illegible]

* 1100-4 S. Ponce De Leon Blvd * St. Augustine, FL 32084 * 904-824-0212 *

Patient's Name ______________________________ Sex M / F Marital Status ____________________

Drivers License # ____________________________ State Issued ______________________________

(If Minor) Grade _____ School __________________________ Parents Name ______________________

Email Address ____

Employer ______________________ Address ____

Work Phone # ____________ Emergency Contact ____________________________ Phone # __________

Names of Children Living with You ______________________________ Hobbies_______________________

Responsible Party for Account _________________________________ Phone # ___________________

Do you have **medical** insurance? [ ] Yes (Insurance Provider ______________________________) [ ] No

Primary Insured's Name __________________________ DOB __________ Insurance ID# ______________

Primary Insured's Address ____

Who do you authorize to release medical information to? ____

Who may we thank for referring you to this office? ____

- All professional services and products must be paid in full at the time of service.
- Any balance incurred as a result of not having a required referral or correct insurance information will be your responsibility.
- If your claim is denied for any reason or we have not received payment within 4-6 weeks from filing you are responsible for the balance due within 30 days.
- I have been given the "Notice of Privacy Practices" for the office of Dr. Horning, Dr. Elkhoury, & Dr. Geis

I request payment of authorized Medicare benefits or other insurance benefits be made to either me or on my behalf t Dr. Horning for any services furnished to me by Dr. Horning. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

By signing below, I acknowledge that I have read and agree to all of the above information:

Patient Signature ____ Date ______________