

Medical History Questionnaire



Patient Information

Name:

Today's Date: / /

Current Address:

Work Phone:

Cell Phone:

Email:

Social Security No:

Date of Last Eye Exam:

Insurance Subscriber's Name:

Subscriber's Social Security No: D.O.B. / /

Guardian (If Applicable): Occupation:

Name of Medical Doctor:

Doctor's Phone:

Parent/Guardian Signature: Date: / /

How did you hear about us?

Insurance Authorization:

I hereby authorize Grove Eye Care to furnish information to insurance carriers concerning my treatment.

Signature: Date: / /

Circle any of the following that you have had:

Crossed Eyes **Lazy Eye** **Drooping Eyelid** **Prominent Eyes** **Glaucoma** **Retinal Disease**

Cataracts **Eye Infections** **Eye Injury** **Surgery:**

Do you wear Contacts? No Yes If yes, what brand do you wear?

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Social History

This information is kept strictly confidential. However, you may discuss your condition directly with the doctor if you prefer.

I would prefer to discuss my social history information directly with my doctor:

Do you drive? Yes No If yes, do you have difficulty driving? Yes No

If yes, please describe:

Do you use tobacco products? Yes No

If Yes, what type and how long?

Do you use drink alcohol? Yes No

If Yes, what type and how long?

Have you ever been exposed to or infected with Gonorrhea, Hepatitis, HIV, or Syphilis?

Yes No If Yes, please explain:

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. Vision Care Plans (such as VSP and EyeMed).
2. Medical insurance (such as BC/BS and Medicare to name a few)
 - Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.
 - Medical insurance must be used if you have eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
 - If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to another. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
 - We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.

Acknowledgment of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed on the Notice. I further understand that the practice will offer me updates to this Notice should it be amended, modified, or changed in any way."

Signature: Date: / /

Communications from our Office

We would like to send you text and/or email messages with appointment reminders, future specials and events. We will NOT share your email or phone number with anyone. It will strictly be used for reminder messages and future events and specials from Grove Eye Care. Your consent is not a condition of purchase.

Email Address:

Signature: Date: / /