TODAY'S VISION
THE ONE TO SEE®

HEALTH HISTORY FORM

Last Name_____ **First Name**_____ **MI**____

Date of Birth (mm/dd/yyyy)_____ **Nickname**_____

Occupation_____ **Referred by** _____ **Date**_____

Medical Information

What is your general health?_____

Do you have problems with any of these systems? (Please circle Yes or No)

Gastrointestinal	Yes/No	Nervous system	Yes/No	Blood/lymph	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Allergic/immunologic	Yes/No
Cardiovascular	Yes/No	Muscles/bones	Yes/No	Headaches	Yes/No
Respiratory	Yes/No	Skin	Yes/No	Mental health	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Sleep Apnea	Yes/No
High Cholesterol	Yes/No	Endocrine (diabetes)	Yes/No	Use C-Pap device?	Yes/No

Other health problems_____

Allergies to medication Yes/No Which?_____Reactions?_____

Current Meds (incl. OTC, & Supplements)_____

Diabetes? Yes/No Type_____Date of diagnosis_____

Any operations? Yes/No What kind?_____When?_____

Family doctor- full name _____Telephone_____

Social History

Do you use tobacco products? Yes/No If yes, type/amount/how long: _____

Do you drink alcohol? Yes/No If yes, type/amount/how long: _____

Hobbies:_____ Computer Use:_____

Family History

Cataracts – relation_____ Retinal detachment – relation_____

Glaucoma – relation_____ Diabetes – relation_____

Macular degeneration-relation_____ High blood pressure – relation_____

Personal Eye Information

Date of last eye examination_____Last eye doctor or clinic_____

Do you have any eye conditions or problems? Yes/No What kind?_____

Have you had any eye operations? Yes/No Type_____Date_____

Have you had an eye injury? Yes/No Type_____Date_____

Do you use any eye drops? _____ How Often? _____ Last Used? _____ Brand? _____

Glaucoma?	Yes/No	Cataracts?	Yes/No	Blurred vision?	Yes/No	Excessive Tearing?	Yes/No
Macular degeneration?	Yes/No	Retinal detachment?	Yes/No	Dry eyes?	Yes/No	Sandy/Gritty Feeling?	Yes/No
Wear glasses?	Yes/No	Wear contacts?	Yes/No	Burning ?	Yes/No	Fluctuating Vision?	Yes/No

Sleep Under Ceiling Fan? Yes/No

Additional information_____

Concerns about your vision_____

Signatures

Patient's Signature:_____ **Date**_____ **Doctor Signature:**_____ **Date**_____

(Parent if Patient a Minor)

Medical Update:

1. Patient's Signature:_____ ☐ No changes Doctor :_____
   Date_____
2. Patient's Signature:_____ ☐ No changes Doctor:_____ Date_____

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Name: _____ **DOB**_____

Street: _____

City: _____ **State:** _____ **Zip:** _____

SSN #: _____ **M** ☐ **F** ☐ **Single** ☐ **Married** ☐ **Other**_____

Daytime Phone #: _____ **Home#:**_____

Cell#: _____ **OK to text:** ☐ **Email:** _____

Occupation: _____ **Employer:** _____

Emergency Contact _____ **Emergency Contact Phone #:** _____

Payment Policy: It is customary to pay for professional services when rendered. Checks: Dishonored checks will be electronically debited from your account for the check amount plus a processing fee of $30.00.

Appointment Policy: Our office charges $30.00 for missed appointments and appointments cancelled without 24 hours notice. This fee is not billable to insurance.

Consent to Treatment and Authorization of Charges: I am an adult 18 years of age or older, or am the parent/guardian of the minor child whose name appears below and hereby authorize TODAY'S VISION SUGAR LAND, P.A. to perform such eye care and treatment on me or my minor child as it deems appropriate and consent to such care and treatment, I further authorize my child to order and purchase goods and services and agree to pay for them whether performed on me or my child.

Assignment of Benefits: I hereby assign payment of authorized insurance (Medicare, Medicaid or any other third-party payor) to which I am entitled to be made to TODAY'S VISION SUGAR LAND, P.A. for any goods or services furnished. I also authorize Today's Vision to release medical information to my insurance company(ies) now or in the future for claim consideration purposes. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that the filing of a claim for any services rendered **does not guarantee payment** from my insurance company. I fully understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patients with Insurance: Our staff will assist you in dealing with your insurance company by verifying your benefits using the member services phone number given on your insurance card; however, **this verification is not a guarantee of payment, and it is your responsibility to know and understand your own insurance benefits, coverage and authorization requirements,** Additionally, all amounts owed by patients under contracted insurance plans (co-pays, deductibles, and non-covered services) are payable at the time of service. **Any service that is rendered by this office, which is not a covered benefit under your insurance policy, is your responsibility to pay.** In order to process your insurance claim you must present your insurance card or voucher at the time of service. Failure to do so may result in denial of your claim.

OPTOMAP RETINAL SCREENING AND DILATION CONSENT

A Dilated Fundus Exam is recommended during your vision examination. Dilation allows the Doctor a better view of your retina. This allows the Doctor to screen for problems that can occur due to systemic diseases such as diabetes and hypertension, along with eye issues such as glaucoma macular degeneration, and cataracts. Dilation can blur your vision and make you sensitive to lights. Pupil size generally begins to reduce in about two hours. Any lasting affects such as redness and swelling or ocular pain should be reported as soon as possible. Dilation may also assist in determining the final glasses prescription, especially in young children.

The benefits of the **OPTOMAP Retinal Screening** include an in depth digital view of nearly the entire retina and it provides a permanent record to compare and track potential eye diseases. **OPTOMAP Retinal Screening fees are $49.00.** Insurance docs not cover this service and is not included in the examination fees. In some cases, a patient may have a medical condition that warrants doing the higher mode **OPTOMAP Plus** exam for which our office charges **$176.** The higher mode **OPTOMAP Plus** exam is covered by most medical insurance companies.

Please check your selection, Dilation:	**Please check your selection, OPTOMAP Screening:**
☐ **ACCEPT** ☐ **DECLINE**	☐ **ACCEPT** ☐ **DECLINE**

_____ _____ _____

Signature of Patient or Authorized Representative | Print Name | Date

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____understand that as part of my health care, Today's Vision Sugar Land, P.A. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

Our Privacy Principles:

- The privacy of your health information is important to us.
- We maintain physical, electronic, and procedural safeguards that comply with federal regulations to protect your health information.
- We do not share your health information unless permitted or required by law for treatment, payment, or health care operations, or unless you authorize it.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Today's Vision Sugar Land, P.A. is not required to agree to the additional restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

I prefer to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐OK to mail to home address
- ☐OK to e-mail: _____
- ☐OK to fax to: _____

☐ Work Telephone _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Cell Phone_____
- ☐ OK to text message (example: Appt information)

☐ I DO authorize the release of prescription information / materials to family members or the following persons:

Name(s) _____

or

☐ I do NOT authorize the release of prescription information / materials to family members.

I understand and have been provided with an opportunity to review the *Notice of Privacy Policies* that provides a more complete description of information uses and disclosures.

_____ _____

Patient's Signature Date

FOR OFFICE USE ONLY

☐ Consent received by _____on _____

☐ Consent refused by patient, and treatment refused as permitted.

☐ Consent added to the patient's medical record on _____