PATIENT HEALTH HISTORY

Date:________

Patient Name: **Birth Date:** **Sex:**

Home Phone: **Cell Phone:**

Address: **City:** **Zip:**

Occupation: **Employer:** **Primary Care Physician:**

EYE HISTORY

Do you currently wear ☐ Glasses ☐ Contacts ☐ Nothing

Do you have difficulty when reading up close without lenses ☐Y ☐N with lenses ☐Y ☐N

Do you have difficulty when looking in the distance without lenses ☐Y ☐N with lenses ☐Y ☐N

Are you currently using any prescription or non-prescription drops for your eyes? ☐Y ☐N

If yes, please list:____

Have you ever had eye surgery? ☐ Y ☐ N If yes, please describe below:

RIGHT EYE Type:____Date:__________________

Type:____Date:__________________

LEFT EYE Type:____Date:__________________

Type:____Date:__________________

Have you ever injured your eye? ☐ Y ☐ N Describe:______________________________

Do you have any of the following eye conditions?

☐ Glaucoma
☐ Macular Degeneration
☐ Cataracts
☐ Retinal Tear/Detachment
☐ Lazy Eye
☐ Wandering Eye
☐ Double Vision
☐ Halos
☐ Eye Pain
☐ Redness
☐ Itching
☐ Burning
☐ Crusting on Eyelid
☐ Flashes of Light in Eyes
☐ Light Sensitive
☐ Dryness
☐ Sandy/Gritty Sensation
☐ Foreign Body Sensation
☐ Discharge
☐ Floating Dark Spots in Eyes
☐ Decreased Vision

MEDICAL HISTORY

Are you currently being treated for any of the following?

☐ High Blood Pressure ☐ Diabetes ☐ High Cholesterol ☐ Stroke ☐ Arthritis

Have you had any hospitalizations or surgeries within the last year? ☐Y ☐N If yes, please explain:

List any MEDICATIONS that you take or we can a make a copy if you have a list with you:

1 ________________________ 2__________________________ 3_______________________

4__________________________ 5____________________________ 6_________________________

Do you have any DRUG OR FOOD ALLERGIES? ☐Y ☐N Please list below:

1__________________________ 2____________________________ 3__________________________

4__________________________ 5____________________________ 6__________________________

Please check if you are you currently having any of the following problems with your health:

- ☐ Sudden Weight Loss or Gain
- ☐ Respiratory/Breathing
- ☐ Urinary
- ☐ Skin-Dry, Rashes, Etc.
- ☐ Depression/Anxiety/Confusion
- ☐ Chronic Fever or Fatigue
- ☐ Ear/Nose/Throat
- ☐ Hematological/Lymphatic
- ☐ Muscle/Joint Pain or Stiffness
- ☐ Allergies
- ☐ Heart Problems
- ☐ Gastrointestinal
- ☐ Endocrine/Thyroid
- ☐ Headaches/Seizures/Numbness
- ☐ Arthritis

Alcohol Use: ☐ Never ☐ Rare ☐ Moderate ☐ Daily
Tobacco Use: ☐ Never ☐ Rare ☐ Moderate ☐ Daily

Family Medical/Eye History:

- ☐ Retinal Tear
- ☐ Glaucoma
- ☐ Lazy Eye
- ☐ Diabetes
- ☐ Wandering Eye
- ☐ High Blood Pressure
- ☐ Macular Degeneration
- ☐ Other:____________________________
- ☐ Cataracts

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES:

I acknowledge that I received a copy of Mayville Vision Center, Inc. /Cassandre Hetzer OD, notice of privacy practices.

PATIENT NAME:__________________________SIGNATURE:__________________________DATE:___________

RESPONSIBLE PARTY/REFUNDS

NAME OF RESPONSIBLE PARTY (Patient's Name or Guardian if minor):_________________________________

I, the undersigned, am financially responsible for all items that I order through Mayville Vision Center, Inc. for myself and my family (Example: Contacts, Frames, Eyeglass Lenses, Sunglasses, Examinations). I assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that if I do not notify Kindy Optical or do not pick up my items within 30 days of delivery to the office, I will be financially responsible for these items regardless. The finance charge is 1.5% per month with a $1.00 minimum. I understand that if my account is sent into collections that there will be an additional 35% charge to cover collection fees. I also understand that should I return items for myself or family that there is a $50.00 processing fee withheld from the total refunded. I also understand that my refund will be adjusted to cover any and all fees and chargebacks that my insurance company may have made to Mayville Vision Center, Inc.

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my medical status.

SIGNATURE OF PATIENT/(GUARDIAN-IF MINOR):_____________________________________DATE:___________________

PLEASE INITIAL AND DATE FUTURE REVIEWS OF THIS FORM:

1________________ 2________________ 3________________ 4________________ 5________________