Hillcrest Vision OD PA

Patient Information Form

First Name_____MI _____ Last Name _____

Date of Birth _____ Social Security Number_____

Gender ☐ Male ☐ Female

Mailing Address _____

City _____ State _____Zip Code_____

Home Phone _____Cell Phone _____

Work Phone _____Email Address _____

How would you like to be contacted? ☐Cell Phone ☐Work Phone ☐Home Phone ☐ Text ☐ Email

Employment Status ☐ Unemployed ☐ Employed Full Time ☐ Employed Part Time ☐ Retired

☐ Disabled ☐ Student

Employer/School _____ Occupation _____

Emergency Contact Name _____ Relationship _____

Phone _____

How did you hear about our office? _____

Person Responsible for Payment _____

Insurance Information

Do you have insurance that you will be filing? Yes No

Medical Insurance Company _____ ID number _____

Name of Insured _____

Relationship to Insured: ☐Self ☐Spouse ☐Partner ☐Child ☐ Other_____

Vision Insurance Company _____ID number_____

Name of Insured _____

Relationship to Insured: ☐Self ☐Spouse ☐Partner ☐Child ☐ Other_____

* If you have more than two insurances, please let us know*

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Medical History

First Name _____ Last Name _____Date of Birth _____

Date of last medical exam: _____ Medical Doctor: _____

Date of last eye exam: _____ Previous eye doctor: _____

Please list any medications or supplements you currently take _____

_____

Do you currently have or have ever had the following conditions, check those that apply.

General Health

□ Currently Pregnant or Nursing
□ Developmental Disability
□ Cancer _____
□ Tobacco Use
□ Alcohol Use
□ Drug Use

Allergic/Immunologic

□ Drug Allergy
□ Environmental Allergy
□ Rheumatoid Arthritis

Please list your allergies

_____

_____

Cardiovascular

□ Hypertension/High Blood Pressure
□ Stroke
□ High Cholesterol
□ Heart Disease
□ Previous Heart Attack

Endocrine

□ Diabetes
□ Hypothyroidism
□ Hyperthyroidism

Hematologic/Lymphatic

□ Anemia
□ Leukemia

Neurological

□ Multiple Sclerosis
□ Epilepsy
□ Head Trauma
□ Headaches
□ Fibromyalgia

Respiratory

□ Asthma
□ Emphysema
□ Frequent sinus infection
□ COPD

Ears, Nose, Throat

_____

Eyes

□ Retinal Detachment
□ Glaucoma
□ Cataracts
□ Macular Degeneration
□ Lazy/Crossed Eye
□ Frequent Eye Infections
□ Eye Injury
□ Eye Surgery
□ Eye Allergies
□ Prism in glasses
□ Double Vision
□ Dry Eye

Skin

□ Eczema
□ Rosacea
□ Psoriasis

Musculoskeletal

□ Muscular Dystrophy
□ Osteoarthritis
□ Ankylosing Spondylitis
□ Fibromyalgia

Psychiatric

□ Depression
□ Anxiety
□ Autism
□ Bipolar
□ PTSD
□ ADHD

Gastrointestinal

□ Irritable Bowel Syndrome
□ Ulcerative Colitis
□ Crohn's Disease

Genitourinary

□ Renal Disease
□ Renal Cancer
□ Kidney Transplant

Infectious Disease

□ AIDS/HIV
□ Hepatitis
□ Tuberculosis
□ STDs

Please list any conditions you have that are not otherwise listed above_____

Please list any surgeries or hospitalizations _____

Family History

Does any family member (parents, grandparents, siblings, and children) currently have or had any of the following conditions? Please write the relationship to you.

□ Blindness _____
□ Cataract _____
□ Crossed Eyes _____
□ Retinal Disease _____
□ Cancer _____
□ Diabetes _____

□ High Blood Pressure _____
□ Heart Disease _____
□ Thyroid Disease _____
□ Glaucoma _____
□ Macular Degeneration_____
□ Retinal Detachment _____

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Vision Evaluation Form

Name _____ Date _____

What problems or concerns would you like addressed at this visit? _____
_____

List your favorite leisure activities/hobbies – knowing this enables us to find the best vision correction for you:
_____

How many hours a day do you spend on electronic devices (computer/phone/tablet)?_____

1. Do you wear prescription glasses? YES NO
2. Are you interested in purchasing glasses today? YES NO MAYBE
3. Do you wear contact lenses? YES NO
4. Are you planning on getting a contact lens evaluation today? YES NO
5. Do you see halos around lights at night while driving? YES NO
6. Do your eyes…(circle all that apply) Burn Water/Tear Itch Feel Dry
7. Do you see….(circle all that apply) Flashes of light Floating spots
8. If you currently wear glasses, what would you change about them? (Circle all that apply)

Style Comfort Thinner Lenses Less Glare

Sun Protection Scratch Resistant Invisible Bifocal

Wellness Retinal Imaging Consent

As part of your eye exam, Dr. Hall and Dr. McAllister recommend a special diagnostic test called Wellness Retinal Imaging. This highly sophisticated computerized instrument allows us to take high quality digital images of the retina and other structures inside your eye. This procedure assists the doctor in early detection of many disorders, including glaucoma, diabetic retinopathy, macular degeneration, retinal detachments and many other vision-threatening conditions. The images are part of your medical record and can be compared with images in the future, allowing us to observe even the smallest amount of change. We strongly recommend that *all* patients have this procedure performed and it is especially important for people who have personal or family history of glaucoma, macular degeneration or other eye diseases. There is an additional charge of $35. This is NOT covered by most insurances.

_____Yes, I want to have the procedure performed.

_____No, I do not wish to have retinal imaging performed.

FINANCIAL & PRIVACY AUTHORIZATION: We request your signature on file, in the event the office files insurance for you or for any office procedure. This clause applies to **all insurance carriers.**

_____ (Initial here) I hereby authorize release of any medical or incidental information necessary for medical benefit or to obtain payment for services and request that payments of benefits be made to the party who accepts assignment. I understand that I am financially responsible for all charges not paid by my insurance company. Payment for non-covered services is expected at time of visit. A copy of this authorization will remain on file for all future visits.

_____ (Initial here) NOTICE OF PRIVACY PRACTICES: A copy of our privacy policies is available on our website and at the front desk upon request. I acknowledge that I have been offered a copy of the Privacy Practices of Hillcrest Vision.

Please list persons with whom we may discuss your health/account information:

_____ _____

Signature_____ **Date**_____