Adult Medical History Questionnaire

Patient Name: _____ Today's Date: _____ / _____ / _____

General Health

Physician: _____ Date of Last Physical: ____ / ____ / ____

REVIEW OF SYMPTOMS

Constitutional
☐Yes ☐No Fever
☐Yes ☐No Weight Loss/Gain
☐Yes ☐No General Fatigue

Ear/Nose/Mouth/Throat
☐Yes ☐No Allergies/Hay Fever
☐Yes ☐No Sinus Congestion
☐Yes ☐No Chronic Cough
☐Yes ☐No Dry Mouth/Throat

Integumentary
☐Yes ☐No Eczema
☐Yes ☐No Herpes
Type:_____
☐Yes ☐No Rash

Respiratory
☐Yes ☐No Asthma
☐Yes ☐No Chronic Bronchitis
☐Yes ☐No Emphysema/COPD

Neurological
☐Yes ☐No Headaches
☐Yes ☐No Migraines
☐Yes ☐No Seizures

Vascular/Cardiovascular
☐Yes ☐No Angina/Chest Pain
☐Yes ☐No High Cholesterol
☐Yes ☐No High Blood Pressure
☐Yes ☐No Vascular Disease
☐Yes ☐No Cong. Heart Failure

Gastrointestinal/Urinary
☐Yes ☐No Diarrhea/Constipation
☐Yes ☐No Kidney _____
☐Yes ☐No Bladder _____
☐Yes ☐No Prostate _____

Lymphatic/Hematologic
☐Yes ☐No Anemia
☐Yes ☐No Bleeding Problems
☐Yes ☐No Chronic Cough

Bones/Joints Muscles
☐Yes ☐No Arthritis
☐Yes ☐No Rheumatoid Arth.
☐Yes ☐No Muscle Pain

Endocrine
☐Yes ☐No Thyroid
☐ Hyperthyroid
☐ Hypothyroid
☐Yes ☐No Diabetes
☐ Type 1
☐ Type 2
years _____

Psychiatric
☐Yes ☐No Depression
☐Yes ☐No Bipolar
☐Yes ☐No ADHD

Immunologic
☐Yes ☐No HIV/AIDS

Medications / Allergies / Surgeries

Are you allergic to any medications? _____

Are you taking any medications? Please list all (including vitamins/supplements). _____

_____

_____

List all major injuries, surgeries, and hospitalizations you have had. _____

_____

Family History

Has anyone in your family had:

☐Yes ☐No Diabetes ☐Yes ☐No Cancer
☐Yes ☐No Glaucoma ☐Yes ☐No Blindness
☐Yes ☐No Cataracts ☐Yes ☐No Lazy Eye
☐Yes ☐No Macular Degeneration
☐Yes ☐No Retinal Detachment

Social History

☐Yes ☐No Smoke? Amount/Years_____
☐Yes ☐No Drink? Type/Amount_____
☐Yes ☐No Drugs? Type/Amount_____

☐Yes ☐No Pregnant/Nursing? # Children_____

☐Yes ☐No Drive? ☐ In the day? ☐ At night?

Current Visual Correction

☐Yes ☐No Do you wear glasses?

☐Yes ☐No Are you satisfied with your vision in your current glasses?

How old are your current glasses?_____

☐Yes ☐No Do you wear contact lenses?

Type: ☐ Rigid ☐ Soft ☐ Hybrid

Brand of lenses? _____

☐Yes ☐No Do you sleep in CL's?

What solution do you use? _____

How often do you change your lenses? _____

Eye Exam History

☐Yes ☐No Is this your first eye exam?

When was your last exam?_____

Where was your last exam?_____

_____

☐Yes ☐No Were you dilated at last exam?

Today's Exam:

☐Yes ☐No Are you having a full, dilated eye exam?

☐Yes ☐No Do you wish to be fit for contact lenses?

Corrective Options

Do any of the following appeal to you?

☐ Thinner / Lighter Lenses
☐ No-line Bifocals
☐ Anti-glare Treatment
☐ Scratch Resistant Coating
☐ Sunglasses / Sunglass Clip
☐ Darkening / Transition lenses
☐ Safety Glasses
☐ Computer Glasses
☐ Sports Goggles
☐ Golf / Biking / Fishing Rx
☐ Polarized Lenses
☐ Contact Lenses

Ocular Complaints

Are you experiencing any of the following?

☐Yes	☐No	Blurred Vision	☐Yes	☐No	Itching
☐Yes	☐No	Double Vision	☐Yes	☐No	Redness
☐Yes	☐No	Light Sensitivity	☐Yes	☐No	Floaters
☐Yes	☐No	Flashes of Light	☐Yes	☐No	Dryness
☐Yes	☐No	Eye Pain	☐Yes	☐No	Discharge
☐Yes	☐No	Eye Infection	☐Yes	☐No	Tearing
☐Yes	☐No	Eye Strain	☐Yes	☐No	Burning
☐Yes	☐No	Sandy/Gritty Feel	☐Yes	☐No	Twitching
☐Yes	☐No	Lazy/Crossed Eye	☐Yes	☐No	Styes
☐Yes	☐No	Loss of Side Vision			

☐ Other: _____

☐ Other: _____

☐ Other: _____

Visual Needs

Do you do any of the following?

☐ Craft/Sew
☐ Garden
☐ Computer Use
☐ Read Books
☐ Golf
☐ Industrial Work
☐ Music
☐ Shooting
☐ Fishing
☐ Skiing
☐ Team Sports

Ocular History

Have you been treated for/diagnosed with:

☐Yes	☐No	Glaucoma	☐Yes	☐No	Cataracts
☐Yes	☐No	Lazy eye	☐Yes	☐No	Eye Trauma
☐Yes	☐No	Eye Infection	☐Yes	☐No	Eye Surgery
☐Yes	☐No	High Pressure	☐Yes	☐No	Laser Surgery
☐Yes	☐No	Crossed Eye	☐Yes	☐No	Vision Loss
☐Yes	☐No	Macular Degeneration			
☐Yes	☐No	Retinal Detachment			
☐Yes	☐No	Retinal Disease			
☐Yes	☐No	Diabetic Retinopathy/Eye Disease			
☐Yes	☐No	Closed/Narrow Angles			

☐ Other: _____

☐ Other: _____

_____ _____
Doctor Signature Date

PATIENT REGISTRATION FORM

PERSONAL INFORMATION

Patient Name: _____ Today's Date: _____ / _____ / _____

Address: _____ Phone: _____ H / W / C

City: _____ Zip: _____ Phone: _____H / W / C

Email: _____ Birth Date: _____ / _____ / _____

SSN: _____ -_____ - _____ Sex: M / F Occupation: _____

How did you hear of our office? _____

If someone referred you, please indicate their name: _____

May we use your name in thanking this person for their referral?(circle one) YES NO

Employer: _____ Marital Status: _____

Spouse Name and Employer: _____

Emergency Contact: _____ Emergency #: _____

Guardian (If Applicable): _____

INSURANCE INFORMATION

Vision Insurance: Y / NCompany: _____

Subscriber Name: _____ Sub. SSN: _____ - _____ -_____

Subscriber Employer: _____ Sub. DOB: _____/_____/_____

Medical Insurance: Y / N Company: _____

Subscriber Name: _____ Sub. SSN: _____ - _____ -_____

Subscriber Employer: _____ Sub DOB: _____/_____/_____

Please bring both your vision and health insurance cards to your appointment.

Co-pays and deductibles are required on the date of service.

We will bill your insurance company for you, but cannot assure payment. ***You are fully responsible for un-paid balance for products purchased and services rendered.***

Chatham
EyeCare Center
of Dr. Bryn DeBass, Optometrist

Written Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy.

I, _____(print patient's name), have been provided a copy of Chatham EyeCare Center's Notice of Privacy Practices.

I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask any questions to Chatham EyeCare Center if I do not understand any information contained in the Notice of Privacy Practices.

Patient Signature_____ Date_____

_____

_____

Please list all those persons with whom you give Chatham EyeCare Center permission to discuss your private medical and/or financial information with.

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

Chatham
EyeCare Center
of Dr. Bryn DeBass, Optometrist

13995 US Highway 29, Suite 100 Chatham, VA 24531
Phone (434) 432-4394 Fax (434)432-8580
Bryn DeBass, OD, FAAO License # 0618001983

Please carefully read this information and sign below. Feel free to ask our staff any questions you may have.

Statement of Insurance Policy

Please be aware that our office participates with many insurance companies and will make an attempt to work with most all other insurance companies. Please review the information below to clarify our policy concerning insurance related matters.

In the healthcare industry, eye care practitioners fall into a unique category, as they often deal with two completely different forms of insurance: Vision and Medical plans.

Vision Plans cover eye examinations for a healthy eye demonstrating only refractive error (nearsighted, farsighted, astigmatism, etc). These plans are specifically designed to provide some benefit or discount toward services and/or materials in conjunction with routine eye care. Such plans normally clarify that they deal only with routine eye exams and do not cover the diagnosis, treatment or management of any medical conditions.

During the course of a routine eye examination the doctor may find a patient has a medical condition in addition to a refractive error. These conditions can affect the different structures of the eye. When one of these conditions is found, the doctor must alter the examination to include an in-depth study of each affected structure and direct an appropriate course of action to treat or manage the condition. Additional testing may be required for appropriate management of ocular conditions. These examinations and testing should be covered by the patient's medical insurance, but will be subject to any deductibles or copayments as set forth by the patient's policy.

Please note the following information regarding our policy:

- A current insurance card must be presented at the time of service to process a claim.
- Most vision plans that are payment type plans only pay a percentage of the patient's total charges. Discount plans require the patient to pay at special discounted rates.
- We make every effort to pre-certify or clarify insurance benefit information provided we have insurance information 48 hours prior to the appointment.
- While we will make a diligent effort to obtain referrals for services, provided we have the correct primary care physician information, it is the PATIENT'S RESPONSIBILITY TO OBTAIN NECESSARY REFERRALS PRIOR TO THE DATE OF SERVICE.
- We do not guarantee the accuracy of benefit information given to us by the insurance companies. However, we can reasonably predict coverage based on previous experience.
- Please understand that financial responsibility for your account ultimately belongs to you, not your insurance company. You will be responsibility for any payments not covered or paid by your insurance company within the normal processing time.
- Copayments and non-covered charges are due at the time of service.
- This office reserves the right to refuse to file an insurance claim.

Acceptance of Policy and Authorization to File Insurance

I authorize the release of any medical or other necessary information concerning my, or my child/dependant's, care, advice, or treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also authorize and request payment of insurance benefits, otherwise payable to me, be paid directly to the party who accepts assignment. I authorize payment of medical benefits to the physician or supplier for services rendered. I understand that my insurance coverage is a contract between myself and my insurance company and that I am responsible for any balance including co-insurance, non-payment, collecting fees, attorney fees, and court costs due to delinquency. A copy of this form is valid as the original.

I have read and agree to comply with the policies of Chatham EyeCare Center:

Name(print): _____ Signature:_____Date: _____

Chatham
EyeCare Center
of Dr. Bryn DeBass, Optometrist

13995 US Highway 29, Suite 100 Chatham, VA 24531
Phone (434) 432-4394 Fax (434)432-8580
Bryn DeBass, OD, FAAO License # 0618001983

Below are described key policies established by Chatham EyeCare Center. Please carefully read this information and sign below. Feel free to ask our staff any questions you may have.

Payment Policy:

All payments are required at the time services are rendered. This includes all applicable co-payments for participating insurance plans. Chatham EyeCare Center accepts cash, personal checks, Visa, MasterCard and Discover. Any checks require photo identification, with check address matching ID address. We do not accept starter or out-of-state checks. All checks should be made out to "Chatham EyeCare Center". Due to the frequency of bounced checks, there is a service charge of $35.00 for any check returned for insufficient funds. If your check bounces you will owe the original amount of your bill plus the $35.00 service charge. This must be paid within 15 days from notification of it will be processed through the local court system.

Cancellation Policy:

Missed appointments result in a cost to our office, to you, and to other patients who could have otherwise been seen in the time that was reserved for your visit. If you are unable to keep your appointment, please give **24-hours** notice to avoid a $25.00 service charge. We reserve the right to charge for a missed or untimely cancelled appointment. Excessive abuse of scheduled appointments may result in discharge from the practice.

Contact Lens Fitting Policy:

As contact lenses are medical devices, serious damage can occur from misuse. In order to ensure your ocular health is properly maintained, it is required that you own a pair of adequate back-up glasses if your vision without the aid of correction is less than 20/40. Your back-up glasses must correct your vision to 20/40 or better, or need to be updated. This standard ensures that your vision meets the basic vision requirements established by the VA Dept of Motor Vehicles for safe driving. In addition, all contact lens fitting fees must be paid prior to the order of lenses or release of your prescription. Contact lens fitting fees are non-refundable, whether your prescription is or is not finalized. Contact lens prescriptions must be finalized within 45 days of the initial fitting. It is the patient's responsibility to schedule all required follow-up visits and trial lens pick-ups.

Purchasing Policy:

For Glasses and Other Prescription Eyewear: As each pair of glasses is a custom ordered product, **all sales are final** once placed. If you feel there is a problem with your glasses or your prescription is incorrect, any changes must be reported and corrected within 60 days of your original visit. After 60 days, there will be a charge for a re-refraction by the doctor or any changes or modifications to your glasses.

For Contact Lenses: Each contact lens prescription is different and customized for the individual patient. All contact lens purchases are final. Any lens order that is placed - and whether not picked up or needing an exchange will be subject to a $30.00 restocking fee.

Records Policy:

Chatham EyeCare Center maintains patient records for a minimum of five years following the patient's last date of service. If legally required, records may be kept longer. Records are shredded or disposed of in a manner that will protect the privacy of our patients and the confidentiality of their health history.

I have read and agree to comply with the policies of Chatham EyeCare Center:

Name(print): _____ Signature:_____Date: _____

Chatham
EyeCare Center
of Dr. Bryn DeBass, Optometrist

13995 US Highway 29, Suite 100 Chatham, VA 24531
Phone (434) 432-4394 Fax (434)432-8580
Bryn DeBass, OD, FAAO License # 0618001983

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name_____

Patient number _____

Patient address _____

Patient phone number _____

I authorize the professional office of my optometrist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

Detailed description of the information to be released:

To whom may the information be released [name(s) or class(es) of recipients]:

The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____ Patient signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

Source of Authority _____