returning patient history questionnaire

Please print the completed form and bring to your appt. Sending personal health information via email is not secure or recommended.

Thank you for continuing to choose our office for your vision care. In order to provide you with the best care possible, we ask that you update your contact info below:

Name: Mr./Mrs./Miss/Ms./Dr. ____ **Date:** ____________________
(First) (M.I.) (Last)

Have you CHANGED your ADDRESS or EMPLOYMENT since your last visit? If YES, please complete the following:

Address: ______________________________ **City:** ________________ **State:** ________ **Zip:** ____________

Phone (h): (______)______________ **Phone (w):** (______)______________ **Phone (c):** (______)______________

We use your e-mail to provide appointment reminders or notifications about eyewear orders. We will never share your e-mail address.

Please update your E-mail:____

Occupation: ______________________________ **Employer:** ______________________________

MEDICAL INFORMATION

Have you had any changes in your health since your last visit? If so, please describe:

____

Are you currently taking medication? □ **y** □ **n If yes, please list:** ______________________________

____ **Do you use cigarettes/tobacco?** □ **y** □ **n**

Are you allergic to medication? □ **y** □ **n Please list:** ______________________________

Name of primary care physician: ______________________________ **Date of last visit:** ____________________

PATIENT'S EYE HISTORY:

Please describe any problems with your eyes or your vision for which you are seeking treatment today: ____________________

____

____

Are you interested in the following: □ **new glasses** □ **contact lenses** □ **vision correction surgery**

(TURN OVER)

FINANCIAL RESPONSIBILITY:
Payment for all professional services rendered is due at the time of service. If you have health insurance, it is your responsibility to ensure we have correct and current information for your insurance plan. It is also your responsibility to pay the copay at the time of service per our contract with your insurance plan. If you are not using health insurance, Look + See Eye Care offers a self-pay discounted fee schedule. Payment for services rendered is required at the time of service.

____ ___________
Signature of Patient/Responsible Party Date

ASSIGNMENT OF BENEFITS:
I hereby assign all medical benefits, to include major medical benefits, to which I am entitled, to Look + See Eye Care for services rendered. I hereby authorize and direct my insurance carrier (including Medicare, private insurance and any other vision or medical plan) to issue payment(s) directly to Look + See Eye Care for health care services provided to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am financially responsible for copay, coinsurance and deductible at the time of service and for any services rendered that are determined to be "non-covered services" by my plan.

I certify that the insurance information I have provided to Look + See Eye Care is true and that it is my obligation to know my plan's requirements and ensure that they have been fulfilled**. I understand that my insurance(s) may not pay 100% of the amount of the claim for services rendered and that I am responsible for any and all amounts not payable by my insurance(s) that are assigned to me.** I agree to notify Look + See Eye Care of any changes in the information I have provided. This assignment of benefits will remain in effect until revoked by me in writing to Look + See Eye Care.

____ ___________
Signature of Patient/Responsible Party Date

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT:
We keep a record of the health care services we provide to you. You may request a copy of your medical record in writing. We will not disclose your record to others unless you direct us to do so or unless legal authorities authorize or compel us to do so. You may request a copy of your medical record or get more information by contacting the Look + See Eye Care Privacy Officer. Our Notice of Privacy Practices is available at the reception desk and is posted in the clinic. The Notice describes in greater detail how your health information may be used or disclosed, and how you can access your information. You are entitled to a copy of this Notice and it is available at your request.

I acknowledge the Notice of Privacy Practices has been offered to me and is readily available in accordance with the Health Insurance Portability and Accountability Act.

____ ___________
Signature of Patient/Responsible Party Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:
I authorize the release of medical information regarding myself/my dependents and my current condition to my referring, consulting, or treating physicians.

____ ___________
Signature of Patient/Responsible Party Date