Shell Point Optical

MEDICAL HISTORY FORM

NAME:_____DATE: _____

ADDRESS:_____PHONE:_____

BIRTHDATE:_____ LAST EYE EXAM:_____Email Address:_____

How would you like to be contacted for your next eye exam? ____ Post card _____Email

____Telephone

How did you hear about us?_____

Reason for today's visit?:_____

Do you have any allergies to medications? _____No _____Yes; explain_____

_____

Current Medications with dosages**:**

_____

_____

Pregnant/Nursing: _____No _____Yes

Please circle any of the following ocular history (past or present)

*Crossed Eyes/Lazy Eye *Retinal disease *Macular Degeneration *Fuch's Dystrophy

*Loss of Vision *Retinal Tear/Hole *Eye Infections *Trauma to Eyes

* Glaucoma *Retinal Detachment *Eye surgery *Other_____

Please circle any of the following CHRONIC symptoms you have had with your EYES (past or present)

* Itchiness *Floaters *Blurriness of vision *Sensitivity to light *Eyelid Matting

* Burning *Headaches/Migraines *Glare and halos *Sharp Pain *Dull Pain

*

* Excessive Tearing *Grittiness/Scratchy *Depth perception problems *Redness

*Focusing Issues *Dryness *Contact lens problems *Spot over vision *Double Vision

*Flashes of light *Eye Infections *Twitching of the eyelids *Poor Night Vision *Eye discharge

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Please circle any eye diseases that run in the family?

Glaucoma Diabetic Retinopathy Hypertensive Retinopathy

Macular Degeneration Cancer of the Eye Retinal Tear/Detachment/Hole

Fuch's Dystrophy Retinitis Pigmentosa Stargardt's Disease

Best's Disease Other:_____

Do you "have" or have "had" any of the following problems *or* are taking medication for any of the following:

___No ___Yes Asthma/COPD ___No ___Yes Gastrointestinal Problems

___No ___Yes Diabetes ___No ___Yes Heart Problem

___No ___Yes High Blood Pressure ___No ___Yes Musculoskeletal Problems

___No ___Yes High Cholesterol ___No ___Yes Neurologic Problems

___No ___Yes Thyroid Problems ___No ___Yes Psychiatric Problems

___No ___Yes Arthritis ___No ___Yes Respiratory Problems

___No ___Yes Chronic fever, unexpected weight loss/gain ___No ___Yes Urinary Problems

___No ___Yes Ear/Nose/Throat (hearing loss, sinus) ___No ___Yes Seasonal Allergies

___No ___Yes Endocrine Problems ___No ___Yes Skin Problems

___No ___Yes Cancer (what kind)_____

Do you currently or have used tobacco products? _____Never

____Current Smoker _____Former Smoker _____If former for how long were you a smoker

Do you drink alcohol? ____Yes ___No

Do you use illegal drugs? ____Yes ____No

Have you ever been exposed to or infected with:

___Gonorrhea ___Hepatitis ____HIV ____Syphilis _____None To All

Payment for all services and products is the responsibility of the patient.

I agree to pay all copays, deductibles, co-insurances and non-covered services as determined by my insurance company.

I understand there is a returned check fee applied to every returned check.

I agree to pay an additional collection fee for all accounts not paid in the time stated on the final monthly statement.

I authorize the release of medical information concerning my illness and treatment by Shell Point Optical to my insurance company.

I also authorize the release of my personal medication information to any doctor whom I may be referred to.

I understand verification of eligibility is not a guarantee of payment as stated by my insurance company.

I authorize payment of my insurance benefits to Shell Point Optical.

We will file all insurance forms if Shell Point Optical is a participating provider for your plan.

We will supply you with an itemized statement which you may submit to your insurance carrier.

Payment in full is required at the time of service to include the purchase of glasses.

_____ _____

Signature of patient or legal guardian Today's Date