NORTHWEST OPTOMETRY ASSOCIATES

Today's Date: _____/_____/_____

Patient History Questionnaire

Full Name: _____ Birth Date: _____/_____/_____

Address: _____ Social Security #: _____

_____ Home Phone: _____

Email Address: _____ Cell Phone: _____

Occupation: _____ Work Phone: _____

Employer: _____ Gender: _____

Medical Doctor: _____ Last Medical Exam: _____/_____/_____

Medical Insurance: _____

Previous Eye Doctor: _____ Last Eye Exam: _____/_____/_____

Vision Insurance: VSP ☐ No ☐ Yes Other _____

Responsible Party if different: _____ **Relationship to Patient:** _____

Phone: _____ **Billing Address if different:** _____

Hobbies: _____ How did you hear about us: _____

★ PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED ★

OCULAR HISTORY

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ☐ No ☐ Yes If yes, what type? ☐ Rigid ☐ Soft ☐ Toric ☐ Multifocal ☐ Monovision

☐ Extended Wear Do you wear them ☐ Full Time ☐ Part Time How frequently do you replace them? _____

Have you had refractive surgery? _____ If yes, Date _____ Type _____

What other services would you like to be evaluated for? ☐ Refractive Surgery ☐ Contact Lenses

☐ Computer Glasses ☐ Reading Glasses ☐ Sunglasses ☐ Driving Glasses

Are you having any visual difficulties? _____ If yes, please explain: _____

Are you currently experiencing any of the following problems with your eyes? **Check the box if "Yes."**

☐ Blurred Vision	☐ Flashes / Floaters in Vision	☐ Redness
☐ Loss of Vision	☐ Halos / Glare / Light Sensiitivity	☐ Excess Tearing / Watering
☐ Loss of Side Vision	☐ Dryness	☐ Eye Pain or Soreness
☐ Distorted Vision	☐ Sandy or Gritty Feeling	☐ Mucous Discharge
☐ Double Vision	☐ Burning	☐ Inflammation of the Eyelid
☐ Tired Eyes	☐ Itching	☐ Styes or Chalazion

Have you been diagnosed with any of the following ocular problems? **Check the box if "Yes."**

☐ Cataracts	☐ Glaucoma	☐ Retinal Detachment / Disease
☐ Crossed Eyes	☐ Lazy Eye / Amblyopia	☐ Dry Eye
☐ Eye Injury	☐ Macular Degeneration	☐ Other _____

MEDICAL HISTORY

List any medications you are currently taking (include oral contraceptives, aspirin, over the counter medications):

_____

_____

_____

Are you allergic to any medications? ☐ No ☐ Yes If yes, which ones: _____

List all major surgeries and/or hospitalizations you have had: _____

_____

REVIEW OF SYSTEMS

Please check the box beside any problem you currently have, or have had, in the following areas:

ALLERGIC / IMMUNOLOGIC ☐ All Normal
- ☐ Allergy / Hay Fever

CARDIOVASCULAR / CARDIAC ☐ All Normal
- ☐ Arteriosclerosis
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol

CONSTITUTIONAL ☐ All Normal
- ☐ Fever
- ☐ Weight Loss / Gain

EARS, NOSE, MOUTH, THROAT ☐ All Normal
- ☐ Sinus Congestion
- ☐ Dry Throat / Mouth

ENDOCRINE ☐ All Normal
- ☐ Diabetes
- ☐ Throid Disease
- ☐ Chronic Fatigue

GASTROINTESTINAL ☐ All Normal
- ☐ Diarrhea / Constipation
- ☐ IBS / Crohn's Disease
- ☐ Ulcers
- ☐ Reflux

GENITOURINARY ☐ All Normal
- ☐ Kidney Disease
- ☐ Ovarian / Uterine Cancer
- ☐ Prostate Cancer

HEMATOLOGIC / LYMPHATIC ☐ All Normal
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Breast Cancer

INTEGUMENTARY (Skin) ☐ All Normal
- ☐ Cancer
- ☐ Rashes
- ☐ Easy Bruising

MUSCULOSKELETAL ☐ All Normal
- ☐ Rheumatoid Arthritis
- ☐ Muscle Pain
- ☐ Joint Pain

NEUROLOGICAL ☐ All Normal
- ☐ Migraines
- ☐ Dizziness
- ☐ Seizures
- ☐ Stroke

PSYCHIATRIC ☐ All Normal
- ☐ Anxiety
- ☐ Depression
- ☐ Memory Loss
- ☐ Hallucinations

RESPIRATORY ☐ All Normal
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Cough

If you checked any of the above boxes or have a condition not listed, please explain further: _____

_____

_____

Are you pregnant and / or nursing? ☐ No ☐ Yes

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

	RELATION TO YOU		RELATION TO YOU
☐ Glaucoma	_____	☐ Diabetes	_____
☐ Cataract	_____	☐ Cancer	_____
☐ Macular Degeneration	_____	☐ Heart Disease	_____
☐ Retinal Detachment	_____	☐ High Blood Pressure	_____
☐ Blindness	_____	☐ Kidney Disease	_____
☐ Crossed Eyes	_____	☐ Lupus / Arthritis	_____

Signature: _____ Date _____/_____/_____

VISION SOURCE

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Northwest Optometry Associates make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ I have read or had explained to me Northwest Optometry Associates Notice of Privacy Practices and agree to continue my care with Northwest Optometry Associates under said terms.
- ☐ I was given the opportunity to read Northwest Optometry Associates Notice of Privacy Practices and declined but wish to continue my care with Northwest Optometry Associates privacy policies.
- ☐ I have read or had explained to me Northwest Optometry Associates notice of Privacy Practices and do not wish to continue my care with Northwest Optometry Associates under said terms.
- ☐ The Notice of Privacy Practices could not be read due to the emergent nature of the care or other reasons described as below.

_____

_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Date

If you are signing as a personal representative of the patient, please include your relationship.

_____ _____

Representative Relationship to Patient

NORTHWEST OPTOMETRY ASSOCIATES

Isaiah J. Fuson, O.D.

Name:_____ DOB:_____

Address:_____City:_____State:_____Zip_____

Home PH. #:_____ Cell PH. #:_____

Employer:_____ Occupation:_____

Person Responsible For Account:_____

Please Check Your Preferred Method Of Payment: Cash:__☐_ Check:__☐__Credit Card:__☐___

Will You Be Using Insurance: YES:_☐_ Private Pay:_☐_

(If yes Please Note We Are Out Of Network For Any HMO's)

Medical Insurance Company:_____ Group #:_____ Policy #:_____

Subscriber's Name:_____ Subscriber's DOB:_____

Secondary Medical Insurance:_____ Group #:_____ Policy #:_____

Subscriber's Name:_____ Subscriber's DOB:_____

Vision Plan: VSP: ☐ None: ☐ Subscriber's Name:_____ DOB: _____

Secondary Vision Plan: VSP: ☐ Subscriber's Name:_____ DOB:_____

(Please Note That VSP Is The Only Vision Plan We Accept)

Referred By:_____

1. **RELEASE OF INFORMATION:** To the extent necessary to determine liability of eligibility for payments and benefits, and to obtain reimbursement, NOA may disclose portions of the patient's record, including his/her records, including, but not limited to insurance companies, healthcare service plans, or workers compensation carriers.
2. **FINANCIAL AGREEMENT:** The undersigned agrees, whether signing as agent, or patient, that in consideration of the services to be rendered to the patient they hereby individually obligate themselves to pay the amount of NOA in accordance with regular rates of NOA and that the undersigned is financially obligated for any services not covered by insurance assignment. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fee and collection expenses. All delinquent accounts shall bear interest at the legal rate. **Payment due when services are rendered.**
3. **ASSIGNMENT OF INSURANCE BENEFITS:** The undersigned authorizes, whether signing as agent or as patient, direct payment to NOA, of any insurance benefits otherwise payable to or on behalf of the undersigned for these outpatient services. It is agreed that payment to NOA pursuant to the authorization by an insurance company, shall discharge said insurance company of any and/or obligation under policy to the extent of such payment.
4. **INFORMATION FOR THE MEDICARE PATIENT:** Deductibles, co-insurance, and any other charges specified as noncovered by Medicare or any other insurance, are the responsibility of the patient.

The undersigned certifies that he/she has read the foregoing and has accepted its terms

_____ _____

Date Patient/Parent/Guardian Signature