



### PATIENT HEALTH HISTORY

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M/F Nickname/Preferred Name: \_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Preferred Telephone # \_\_\_\_\_ Home Work Cell (Phone number will be used for appointment reminders)

In Case of Emergency & Phone #: \_\_\_\_\_

How did you hear about our office/Ideal Eyecare? \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Hobbies: \_\_\_\_\_ Email: \_\_\_\_\_

#### Account Responsible/Subscriber Information (if different from above)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ Sex: M/F

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Preferred Telephone# \_\_\_\_\_ Home Work Cell Used for appointment reminders

Employer: \_\_\_\_\_ Policy # \_\_\_\_\_

Name of Medical Insurance \_\_\_\_\_

Name of Vision Insurance \_\_\_\_\_

#### HIPAA Patient Consent Form

Our Notice of Privacy Practices describes how we may use/disclose protected health information (PHI). You have the right to restrict how your protected health information is used/disclosed for treatment, payment, or healthcare operations. HIPAA (Health Insurance Portability and Accountability Act of 1996) Law allows for the use of this information for treatment, payment, or healthcare operations. By signing this form, you consent to our use of your PHI for treatment, payment, or healthcare operations. We may change the privacy policy as allowed by law. You may revoke this consent in writing at any time, at which point all full disclosures will cease but not be retroactive. Your signature also consents sending appointment reminders/confirmations by phone, email, or text message. My signature indicates my understanding and consent:

Patient/Guardian Signature: \_\_\_\_\_

I give my permission to **Ideal Eyecare** to release information about my medical and or financial to the following person(s) or medical doctor(s) listed here:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

**NOTE:** To all insurance patients: The procedures performed in this office are medical in nature. Professional fees will be submitted to your vision and/or medical insurance. Patients will be billed for any un-met deductibles, co-insurance, or copays. I authorize payment of insurance benefits to **Taylor Vision PC**. I agree to be financially responsible for any balance not paid by my insurance plan. I understand professional fees are non-refundable. I authorize the release of information including diagnosis and records of treatment or examination rendered to me or my dependents during the period of such care to third party payers, billers/collections and/or health practitioners.

**Patient/Guardian Signature** \_\_\_\_\_

**PERSONAL MEDICAL HISTORY:** Please check if any of the following applies to YOU, and list any medications for each condition that you check. If you do not have any of these conditions, please check NONE.

<b>Cardiovascular:</b> <input type="checkbox"/> None <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Disease <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Other:	<b>Constitutional:</b> <input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Trauma/Large Volume Blood Loss <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Other:	<b>Ear/Nose/Throat:</b> <input type="checkbox"/> None <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Other:
<b>Endocrine:</b> <input type="checkbox"/> None <input type="checkbox"/> Non-insulin Dependent Diabetes <input type="checkbox"/> Insulin Dependent Diabetes <input type="checkbox"/> Thyroid Dysfunction <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Other:	<b>Gastrointestinal:</b> <input type="checkbox"/> None <input type="checkbox"/> Crohn's <input type="checkbox"/> Colitis <input type="checkbox"/> Other:	<b>Genitourinary:</b> <input type="checkbox"/> None <input type="checkbox"/> Bladder Dysfunction <input type="checkbox"/> Kidney Dysfunction
<b>Hematologic:</b> <input type="checkbox"/> None <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other:	<b>Integumentary:</b> <input type="checkbox"/> None <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other:	<b>Immunologic:</b> <input type="checkbox"/> None <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Neurofibromatosis <input type="checkbox"/> Other:
<b>Musculoskeletal:</b> <input type="checkbox"/> None <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Other:	<b>Neurological:</b> <input type="checkbox"/> None <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Tumor <input type="checkbox"/> Other:	<b>Psychiatric:</b> <input type="checkbox"/> None <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:
<b>Respiratory:</b> <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Other:	<b>Pregnant:</b> Y / N <b>Nursing:</b> Y / N <b>Alcohol Use:</b> Y / N <b>Amount:</b> <b>Tobacco Use:</b> Y / N <b>Amount:</b>	

Please list any medications that you are currently taking (including herbal or over the counter). Or attach a LIST

1. _____ For	5. _____ For
2. _____ For	6. _____ For
3. _____ For	7. _____ For
4. _____ For	8. _____ For

Do you have any allergies to medication?  No  Yes If yes, please list: \_\_\_\_\_

List major injuries, surgeries, and/or hospitalizations you have had:

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**Eye Health History-Do you (patient) experience any of the following?**

Blurred Vision	N	Y
Flashing lights	N	Y
Dizziness	N	Y
Distorted Vision	N	Y
Painful Eyes	N	Y
Red Eyes	N	Y
Double Vision	N	Y
Watery Eyes	N	Y
Itchy Eyes	N	Y
Burning Eyes	N	Y
Aching Eyes	N	Y
Floaters	N	Y
Lose Place When Reading	N	Y
Light Sensitivity	N	Y
Discharge	N	Y

**Family Ocular History-Has anyone in the patient's family (blood relative) had any of the following?**

Cataracts	N	Y
Glaucoma	N	Y
Diabetes	N	Y
Cornea Disease	N	Y
Macular Degeneration	N	Y
Cancer	N	Y
Crossed Eyes	N	Y
Heart Disease	N	Y
Lazy Eye	N	Y
Retina Disease	N	Y
High Blood Pressure	N	Y

Other: \_\_\_\_\_