**PATIENT HISTORY QUESTIONNAIRE**

EnVision Family EyeCare     Dr. Angela C. Billmayer ~ Optometrist

***IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.***

Last name ________________________________ First name ______________________________ MI __________
Address ___________________________________________ City _________________ State _____ Zip __________
Home Phone (______)_________________ Work (______)________________ Cell (______)____________________
Sex : M / F DOB _________________ Age__________________ Marital Status_____________________
Employer__________________ Occupation__________________ Email____________________________________
Emergency Contact_____________________Relationship:____________ Phone number (_____)____________
How did you hear about us? friend/family ____ yellow pages ____ insurance ____ other ___________
Referred by:________________________________ Date of Last Eye Exam_______________________________

**Medical Insurance**:_______________________________ID# _________________________________________
Group #__________________Policy Holder: ___________________________Policy holder's DOB ___________
Relationship to Insured: Self / Spouse / Child / Other Employer_______________________________
Policy Holder's Address________________________________________ Phone ___________________________

**Vision Insurance:** Circle one: EyeMed / VSP / Other ______________________________________________
Policy Holder________________________________________Policy Holder's DOB _______________________
Employer __________________________________ Last four digits of social security number: ___________

**Personal Medical Information:**

Do you have any of the problems with any of these systems? (**Please circle yes or no**)

| | | | | | |
|---|---|---|---|---|---|
| Gastrointestinal | Yes / No | Endocrine (glands) | Yes / No | Nervous | Yes / No |
| Ears /Nose/ Throat | Yes / No | Blood Lymph | Yes / No | Urinary | Yes / No |
| Cardiovascular | Yes / No | Allergic/ immunologic | Yes / No | Muscles/Bone | Yes / No |
| Respiratory | Yes / No | Headaches | Yes / No | Integumentary (skin) | Yes / No |
| Mental | Yes / No | | | | |

**Please explain any YES answers**__________________________________________________________________

**Diabetes: Yes/ No** Type _______ Date of Diagnosis____________ How well controlled? Well / moderate / poor
Other health problems______________________________________________________________________________

**Current medication (s)**___________________________________________________________________________
**Allergies to medication? Yes / No** Which? _______________________________________________________
Have you had any operations? Yes / No Type? ______________________________ Date ________________________

Family Doctor _______________________________________Phone (_____)________________ Last seen _____________

**Family Medical History: (Please circle yes or no)**

| | | | | | |
|---|---|---|---|---|---|
| Heart Disease | Yes / No | Relationship ____________ | Macular Problems | Yes / No | Relationship___________ |
| High Blood Pressure | Yes / No | Relationship ____________ | Retinal Problems | Yes / No | Relationship __________ |
| Diabetes | Yes / No | Relationship ____________ | Lazy eye/ Eye turn | Yes / No | Relationship __________ |
| Glaucoma | Yes / No | Relationship ____________ | Cancer | Yes / No | Relationship __________ |
| Corneal Problems | Yes / No | Relationship ____________ | Cataracts | Yes / No | Relationship __________ |

**Personal Information: Check boxes for all that apply**

- □ Do you work on a computer? Hours / Day ______________
- □ Would you like your eyeglass lenses to be thinner or lighter? Yes / No
- □ Do you currently wear contact lenses? Brand ______________ How often do you sleep in them?_______________
  How often do you dispose of them? _______________ Any problems with them? ___________________________
- □ Do you spend time outdoors? Hours / Week? ____________
- □ Have prescription sunglasses? Yes / No
- □ Would you like information on Lasik Vision Correction? Yes / No
- □ Do you have more than one pair of Rx glasses? Yes / No
- □ Do you have children? Yes / No
- □ Do you smoke? Yes / No
- □ Do you consume alcohol? Yes / No If so, how many drinks per week / month? ____________________
- □ Are you pregnant? Yes / No

**(Continued on back)**

**Personal Information** (continued) **Check boxes for all that apply:**

***Have you ever been diagnosed or treated*** for any of the following:

- ◻ Corneal problems
- ◻ Eye infection (s)
- ◻ Eye injury
- ◻ Glaucoma
- ◻ Cataracts
- ◻ Strabismus (eye turn)
- ◻ Macular degeneration
- ◻ Retinal holes/ tears/ detachments
- ◻ Iritis / uveitis
- ◻ Other eye disorders ______________________________

***Do you, or have you ever experienced***:

- ◻ Blurred Vision
- ◻ Double Vision
- ◻ Tearing
- ◻ Headaches
- ◻ Flashing lights
- ◻ Floaters
- ◻ Grittiness
- ◻ Itching
- ◻ Dryness
- ◻ Sunlight sensitivity
- ◻ Trouble seeing at night
- ◻ Eyestrain
- ◻ Burning

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**All professional services are charged to the patient**. Your insurance may help towards these costs. Final benefit decisions are made by your insurance company, and may be different than originally quoted when we verify them. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage, including interest that may be charged to the account. It is customary to pay for all services when rendered unless other arrangements have been made in advance. **If your insurance requires a referral, it is your responsibility to obtain that referral.** Deductible, co-payment, and "non-covered" amounts are the responsibility of the patient. Any balance outstanding for 60 days or more shall accrue compound interest at a rate of 10% per month. In the event of collection, you are responsible for all the costs of collection and a 25% attorney collection fee. **In the event you are unable to keep your scheduled appointment, please give a 24 hour notice. Failure to provide a 24 hour notice of cancellation will result in a $50 missed appointment/late cancellation charge.**

**Insurance Authorization and Assignment**

I hereby authorize EnVision Family EyeCare to release information to insurance carriers concerning my ocular health and treatment. I hereby assign to Envision Family EyeCare all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance. This authorization is to remain in effect until I choose to revoke it in writing.

**HIPAA Compliance Acknowledgement**

I acknowledge that I have been offered a copy of Dr. Angela Billmayer's Notice of Privacy Practices to read and retain if I should so desire.

**Patient Signature (Guardian if Minor)** ________________________________Date________________

*Thank you for choosing our practice for your eye care needs. We look forward to providing you with the personalized care and excellent service you deserve. Our goal is for our patients to see well not only for today, but for a lifetime! If you ever have any questions or comments, please let us know.*

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**For office use only:**

Reviewed: __________ (Initials) Date: __________ Changes: ______________________________

______________________________________________________________

Reviewed: __________ (Initials) Date: __________ Changes: ______________________________

______________________________________________________________

Reviewed: __________ (Initials) Date: __________ Changes: ______________________________

______________________________________________________________

Reviewed: __________ (Initials) Date: __________ Changes: ______________________________

______________________________________________________________

**Envision Family EyeCare... Healthy Eyes for a Lifetime!**