Patient History Questionnaire

Name:_____ Today's Date:_____
Address:_____Birth Date:_____
City:_____Zip Code:_____Social Security #:_____
Phone (home) (___)_____Phone (cell) (___)_____
Email:_____ Phone (wk)(___)_____
Employer:_____Occupation:_____
Referred by:_____
Race: (Circle all that apply): American Indian/Alaska Native Asian African American
White Decline to Specify

Ethnicity: Hispanic/Latino Not Hispanic/Latino Decline to Specify

Personal Eye Information

Reason for today's visit:_____
Do you currently wear glasses? Y/N Do you currently wear contact lenses? Y/N
Date of last Eye Examination:_____
Have you had any eye operations? Y/N Type_____Date:_____
Have you had an eye injury? Y/N Type_____Date_____
Do you have cataracts? Y/N Glaucoma? Y/N Macular Degeneration?_____
Blurred Vision? Y/N Other Eye Problems? Y/N Describe:_____

Medical information

How is Your General Health?_____
Do you have Diabetes? Y/N High Blood Pressure? Y/N
Do you have problems with any of these systems? (Please circle all that apply)
Respiratory Y/N Ear/Nose/Throat Y/N Cardiovascular Y/N
Gastrointestinal Y/N Nervous Y/N Mental Y/N
Musculoskeletal Y/N Blood/Lymph Y/N Skin Y/N
Allergic/Immunological Y/N
If yes, Please Explain:_____
Name of Primary Care Provider:_____Phone:(___)_____
Current Medications:_____
Medication Allergies:_____Seasonal Allergies?_____
Do you use cigarettes/tobacco? Y/N Drink Alcohol? Y/N

Family History

Diabetes? Y/N High Blood Pressure? Y/N Cataracts? Y/N Glaucoma? Y/N
Macular Degeneration? Y/N Retinal Detachment? Y/N Unexplained Blindness? Y/N
Other Eye Conditions? Y/N

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have been given the opportunity to review and/or have received a copy of Larsen Eye Group's Notice of Privacy Practices.

Signature:_____Date:_____
If signing as a parent or guardian, please note the name of the patient_____

Health related communications & reminders by cell phone texting and Email:
I permit Larsen Eye Group to communicate concerning vision-related issues & reminders by texting or email.
Signature_____Date_____

Insurance/Payment

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Larsen Eye Group.

VISION Insurance_____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date ___/___/_____

MEDICAL Insurance_____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____

If patient is a minor, please list responsible party:
Name_____
Relationship to patient_____

I assign all of my medical/vision benefits to Larsen Eye Group/Edwin K. Larsen OD and authorize said assignee to release all information necessary to secure payment from my insurance company. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company, and that final determination can only be made when the claim is processed. I understand that if some fees are not paid by my insurance, I am still responsible and will be billed for them.

Patient's or Guardian's Signature:_____Date_____

*Payment for materials and services are due when services are rendered. We require payment in full for materials in advance of processing an order (this includes all extra charges not covered by vision plans). If you have questions, please ask!

Thank you for choosing Larsen Eye Group! Our mission is to provide the highest quality vision care for you, your family and our community for years to come.

OFFICE POLICIES

Personal Checks and Bounced Checks

*Personal checks are not accepted from new patients.
*It is the sole discretion of Larsen Eye Group whether or not personal checks are accepted from existing patients.
*Any bounced personal checks are subject to a fee of $25, which is to be paid, in addition to the original amount on the check, within 90 days.

Picking Up Eyeglasses and Contact Lenses

All eyeglasses and contact lenses that have been prescribed, fitted, and purchased by the patient will be kept in the office for a total of **one year** from the date of purchase. If the patient does not pick up his/her eyeglasses or contact lenses within that year, we will subsequently donate them to The Lions Club International.

Return Policy for Eyewear and Contact Lenses

Eyeglasses are custom-made for you and you only! There are **no returns or exchanges for any purchased eyewear** (including frames and lenses). Occasionally, there is a need for the prescription to be adjusted, and these changes are included at **no charge** within 90 days of purchase. If there are any discrepancies between the doctor's prescription and the lenses manufactured by the lab, these changes will be provided at **no charge**.

With regard to the sale of non-specialty soft contact lenses, any **unopened and unmarked boxes** may be returned for a full refund, or exchanged, within 6 months if there has been a change to your prescription. However, all sales of **specialty** gas permeable (rigid) and special-order toric (high astigmatism) contact lenses are final. During the trial period in determining the proper prescription for such specialty lenses, any exchanges or returns will be granted at **no charge** so long as enough time is given for the lenses to be mailed back to the manufacturer, in order to meet the manufacturer's 90-day exchange/return policy.

I have read and understand all aspects of the above policies.

Name:_____

Signature:_____Date:_____