MEDICAL HISTORY

Name ______________________________Nickname__________ Date ______/______/______

Address ______________________________ Phone ______________

City______________________ State _____ Zip__________ Work Phone ______________

Guardian (if applicable)______________________________ Occupation ______________

Birthdate _____/_____/_____ SSN _____/_____/_____ Last Eye Exam _____/_____/_____

Do you have vision insurance? ❐No ❐Yes If yes, insurance carrier ______________________

Do you have health insurance? ❐No ❐Yes If yes, insurance carrier ______________________

Whom may we thank for your referral?______________ How did you find out about us?__________

Medical History

Do you have any allergies to medication? ❐ No ❐ Yes If yes, explain ______________________

____

List medications you take (including oral contraceptives, aspirin, over-the-counter medications, and home remedies)

____

____

Last Medical Checkup____/____/____ Name of Primary Care Physician______________________

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

____

List any of the following that you have had – crossed eyes, lazy eye, drooping eyelid, glaucoma, cataracts, retinal disease, eye infections, or eye injury______________________

Are you pregnant and/or nursing? ❐ No ❐ Yes Are you interested in vision correction surgery? __ No __Yes

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, how old is your present pair of lenses? ______________

Type of contact lenses: ❐ Rigid ❐ Soft ❐ Extended Wear ❐ Other Are they comfortable? ❐ No ❐ Yes

Family History

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

Disease/Condition	No	Yes	?	Relationship
Blindness	❐	❐	❐	______________
Cataract	❐	❐	❐	______________
Crossed Eyes	❐	❐	❐	______________
Glaucoma	❐	❐	❐	______________
Macular Degeneration	❐	❐	❐	______________
Retinal Detachment/Disease	❐	❐	❐	______________
Arthritis	❐	❐	❐	______________
Cancer	❐	❐	❐	______________
Diabetes	❐	❐	❐	______________
Heart Disease	❐	❐	❐	______________
High Blood Pressure	❐	❐	❐	______________
Kidney Disease	❐	❐	❐	______________
Lupus	❐	❐	❐	______________
Thyroid Disease	❐	❐	❐	______________
Other	❐	❐	❐	______________

– OVER –

Social History – This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I prefer to discuss my Social History information directly with the doctor.

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes If yes, please describe:

____

Do you use tobacco products? ☐ No ☐ Yes If yes, type/amount/how long ____________

Do you drink alcohol? ☐ No ☐ Yes If yes, type/amount/how long ____________

Do you use illegal drugs? ☐ No ☐ Yes If yes, type/amount/how long ____________

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems

Do you currently, or have you ever had, any problems in the following areas:

	No	Yes	?
Constitutional			
Fever, Weight Loss/Gain	☐	☐	☐
Integumentary			
Skin	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Eyes			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
Endocrine			
Thyroid/Other Glands	☐	☐	☐

	No	Yes	?
Ear, Nose, Mouth, Throat			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Vascular/Cardiovascular			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Gastrointestinal			
Chronic Diarrhea	☐	☐	☐
Chronic Constipation	☐	☐	☐
Genitourinary			
Genitals/Kidney/Bladder	☐	☐	☐
Bones/Joints/Muscles			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Lymphatic/Hematologic			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Allergic/Immunologic	☐	☐	☐
Psychiatric	☐	☐	☐

If you answered yes to any of the above, or have a condition not listed, please explain and list medications:

____

____

Email address ______________________ I give you permission to occasionally email me about upcoming events/sales/new products ____N____Y

If patient is a minor, I hereby give the doctor permission to treat(name) ______________________

Parent/Guardian's Signature ______________________

Doctor's Signature ______________________ Date ______/______/______

Name ______________________________ Date ______________

Your Occupation ______________________________

Employer ______________________________

Business Phone ______________________________

Spouse's Name ______________________________

Spouse's Occupation ______________________________

Employer ______________________________

Business Phone ______________________________

NOTICE OF PRIVACY PRACTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

Disclosure of your personal health information may include but may not be limited to purposes of treatment, payment and other healthcare operations. Other purposes may include those that are permitted or required by the Health Insurance Portability and Accountability Act (HIPAA) to disclose health information without the patient's written consent of authorization, unless specifically prohibited by any law other than HIPAA.

Any other use of personal health information will be made only with the patient's written authorization and can be revoked by the patient at any time.

The patient has the right to request restrictions on certain uses and or disclosure of personal health information. The law does not require us to agree to these requested restrictions.

The patient has the right to receive confidential communications to personal health information.

The patient has the right to inspect, copy, and amend his personal health information, as well as receive an accounting of disclosures of same information.

If the patient received this notice electronically, they have the right to receive a paper copy upon request.

This office is required by law to maintain the privacy of your personal health information and to provide the patient with this notice of our legal duties and privacy practices with respect to personal health information.

This office is required to abide by the terms of this notice currently in effect.

This office reserves the right to make any changes in our privacy practices in the future. An explanation will be provided and made available to all patients.

For further information with regards to this notice, please contact:

Covington Family Optometry
James D. Barber, O. D.
Robert L. Elwell, Jr., O. D.
5165 Cook Street
Covington, GA 30014
770-787-2400

This notice is effective April 2003

Signed: ______________________________ **Date:** ____________

Covington Family Optometry

James D. Barber, O.D., LLC   Robert L. Elwell, Jr., O.D.

5165 Cook Street Covington, GA 30014

Phone 770-787-2400   Fax 770-787-4000

covfamopt@gmail.com

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Here at Covington Family Optometry, we want to make sure you have the necessary information to be reimbursed for all covered services. Please understand your insurance only covers services when their rules are met.

- **Insurance coverage**: It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and authorization requirements as well as vision services. This information is furnished by your insurance carrier. We make copies of your insurance cards assuming the coverage is active at the time of your visit. If your coverage is not in effect at the time of services, you will be responsible for payment.

- **Insurance Changes**: If you have any changes in your insurance coverage, please notify us. Failure to do so may result in a claim denial and you will be billed.

- **Co-Payments, Co-Insurance and deductibles**: Co-Insurance and co-payments are the patient's/policy holder's responsibility. Co-payments are due at the time of service. Deductibles are the responsibility of the patient/policy holder.

- **Refractions:** Insurance companies do not pay for refractions unless you are entitled to a routine eye exam or have a separate vision plan. In these instances, refraction fees are due at the time of service.

- **Insurance Payments:** If by error an Insurance check is sent to you, it should immediately be forwarded to our office along with a copy of the explanation of benefits (EOB).

- **Self Pay Patients:** Self pay patients must pay in full for the examination and any glasses or contacts that are needed. Pricing will be discussed at the time you are fitted for the glasses/contacts.

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Name of Patient **(PRINT)**   Signature   Date

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Signature of Patient Representative   Relationship to Patient   Date