Patients Name: Last: MI: First: Nickname:

DOB: / / SSN: - - Sex: M F Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Mailing Address: Suite, Apt #:

City: State: Zip: E-Mail:

Home Ph #: ( ) - Daytime #: ( ) - Cell Ph #: ( ) -

Best # to be reached: ❑ Home ❑ Daytime/Work ❑ Cell : Special Instructions:

Employment Status: ❑ Full-Time ❑ Part-Time ❑ Self-Employed ❑ Student ❑ Not-Employed ❑ Retired ❑ Military

Employer: Occupation:

Preferred Language: ❑ English ❑ Spanish ❑ French ❑ German ❑ Latin ❑ Other: Please List:

Race: ❑ White ❑ Black or African American ❑ Chinese ❑ Hispanic ❑ Indo-American ❑ Other: Please List:

Ethnicity: ❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑ Native Hawaiian/ Other Pacific Islander

We need to know who has Financial Responsibility and who is the Primary / Guarantor on your Insurance

Spouse/Parent/Guardian: Last: MI: First: Relationship:

DOB: / / SSN: - - Employer: Best Ph #: ( ) -

Is the Address the same as Patients: ❑ Yes ❑ No If No, Please List Mailing Address Below:

Mailing Address: Suite, Apt #:

City: State: Zip: E-Mail:

We need to know who to contact in case of a Medical Emergency

Is your Spouse/Parent/Guardian your emergency contact? ❑ Yes ❑ No If No, Please List Below:

Emergency Contact Name: Relationship: Ph #: ( ) -

We need to know about your Insurance **Please Fill out what you know and give your Ins Cards to our Staff**

Primary **Medical** Carrier: Who is the Primary Member:

Secondary **Medical** Carrier: Who is the Primary Member:

Vision Insurance Carrier: Who is the Primary Member:

Secondary **Vision** Carrier: Who is the Primary Member:

_____ _____

Signature of Patient or Guarantor Today's Date

Welcome to EyeXcel

EyeXcel

Medical History Questionnaire

David A. Patton, O.D., Bruce D. Gilliland O.D., Frank A. Carusone, O.D.

Patient's Name: Last: MI: First: Sex: M F : DOB: / /

Best # to be reached: ( ) - : Ext: : What number is this? ❑ Home ❑ Daytime/Work ❑ Cell

Last Eye Exam: / / Name of Optometrist or Ophthalmologist (Eye doctor):

Primary Care Physician: Physician's Phone# Last Medical Exam: / /

Referring Physician: Physician's Phone #: Physician's Specialty:

CURRENT VISION ❑ Currently Unaided ❑ Wearing Glasses ❑ Wearing Contacts

OCULAR HISTORY **Have you had any of the following?**

❑ Nearsighted	❑ Lazy Eye	❑ Drooping Eyelid	❑ Prominent Eye	❑ Retinal Disease
❑ Farsighted	❑ Glaucoma	❑ Eye Infections	❑ Cataracts	❑ Eye Injury
❑ Astigmatism	❑ Crossed Eyes	❑ Corneal Abrasion	❑ Eyes "Hurt or Tired"	❑ Eyes Bloodshot
❑ Tilting Head	❑ Bumping Into Objects	❑ Excessive Blinking	❑ Closing One Eye	❑ Covering One Eye

SURGICAL HISTORY

Please list all Ocular Surgeries (for your EYES): _____

_____

Please list all injuries, surgeries, and/or hospitalizations you have had: _____

_____

_____

MEDICAL HISTORY **We will ask about today, but in the PAST, have you ever had problems in the following areas?**

Constitutional	**Neurological**	**Ear, Nose, Throat**	**Genitourinary**	❑ Distorted Vision/ Halos
❑ Fever	❑ Headaches	❑ Allergies	❑ Kidney	❑ Double Vision
❑ Weight loss/gain	❑ Migraines	❑ Hay Fever	❑ Bladder	❑ Dryness/ Dry Eye
Cardiovascular	❑ Seizures	❑ Sinus Congestion	❑ Genitals	❑ Mucous Discharge
❑ Diabetes	**Respiratory**	❑ Chronic Cough	**Bones, Joints, Muscles**	❑ Redness
❑ High Blood Pressure	❑ Asthma	❑ Dry Throat / Mouth	❑ Rheumatoid Arthritis	❑ Sandy or Gritty Feeling
❑ Vascular Disease	❑ Emphysema	**Endocrine**	❑ Muscle Pain	❑ Itching/ Burning
❑ Heart Condition	❑ Chronic Bronchitis	❑ Thyroid	❑ Joint Pain	❑ Excess Tearing
Gastrointestinal	**Hematological**	**Integumentary**	**EYES**	❑ Glare/ Light Sensitivity
❑ Diarrhea	❑ Anemia	❑ Skin Problems	❑ Blurred Distance	❑ Eye Pain/ Soreness
❑ Constipation	❑ Bleeding Problems	❑ **Psychiatric**	❑ Blurred Near	❑ Flashes/ Floaters

DIABETIC: ❑ Yes ❑ No : If yes, which type: ❑ Suspect ❑ Type II ❑ Juvenile : What is your A1C : _____

CONDITIONS

Please list any/all medical conditions that have not been covered or mentioned above: If **cancer**, please list which type:

_____

_____

_____

MEDICATIONS

List ALL Medications you take and explain for which condition they are treating: _____

_____

_____

Do you have any allergies **to medications?** ❑ Yes ❑ No If yes, list and explain: _____

_____

_____

ALLERGIES

Please list all allergies, regular and seasonal, and everything you are allergic to: _____

_____

_____

FAMILY HISTORY	**Mother:**	**Father:**	**Sister:**	**Brother:**	**Grandmother:**	**Grandfather:**	**Aunt:**	**Uncle:**	**Cousin**
Arthritis	❑	❑	❑	❑	❑	❑	❑	❑	❑
Blindness	❑	❑	❑	❑	❑	❑	❑	❑	❑
Cataract	❑	❑	❑	❑	❑	❑	❑	❑	❑
Crossed Eyes	❑	❑	❑	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑	❑	❑	❑
Macular Degeneration	❑	❑	❑	❑	❑	❑	❑	❑	❑
Retinal Detachment	❑	❑	❑	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑	❑	❑	❑
Please List Type and Who For: _____									
_____									
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑	❑	❑	❑
Lupus	❑	❑	❑	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑	❑	❑	❑
Other: _____	❑	❑	❑	❑	❑	❑	❑	❑	❑

SOCIAL HISTORY

Do you drive? ❑ Yes ❑ No If yes, do you have visual difficulties driving? ❑ Yes ❑ No If yes, explain: _____

_____

Do you have any occupational concerns related to vision? ❑ Yes ❑ No If yes, explain: _____

_____

Smoking	**Alcohol Use**	**Narcotics**	❑ Gonorrhea
❑ Never	❑ None	❑ None	❑ Hepatitis
❑ Current Smoker	❑ Social Use	❑ Recreational	❑ HIV
❑ Former Smoker	❑ Regular Drinker	❑ Dependent	❑ Syphilis

DEVELOPMENTAL HISTORY Pediatric Patients Only

Birth	**Activity**	**Speech**	**Motor Development**
❑ Normal	❑ Normal	❑ Normal	❑ Normal
❑ Premature	❑ Hyperactive	❑ Difficulties	❑ Reduced motor skills
❑ Low Birth Weight	❑ Learning Difficulties	❑ Babbles	❑ Autism
❑ Complications	❑ Becomes Irritable	❑ Non-verbal	❑ Mentally Challenged

This information is kept strictly confidential.

By signing this form, I consent to treatment for myself and/or on behalf of the minor for which this information pertains. I give permission for the doctor/s/technicians to examine, diagnose, and initiate treatment as deemed appropriate. I attest that I am of sound mind and in good mental health to have filled out this medical history form for myself or on behalf of the minor seeking medical services to the best of my knowledge. I further attest that I am the parent or legal guardian of the minor and have the authority to authorize care and treatment.

_____ Today's Date: ____/____/_____

Patient Signature / Minor's Printed Name

_____

Signature of Parent/ Legal Guardian

_____ Date Signed Off: ____/____/_____

Doctor's Signature

Name: _____

DOB: _____

David A. Patton, O.D.
Bruce D. Gilliland, O.D.
Frank A. Carusone, O.D.

Pharmacy

IF the doctor needs to write you a prescription, we will send the Rx to your pharmacy electronically or call it in for you. We need your pharmacy preference.

Name of Pharmacy: _____ Address: _____

Phone: _____ Special Instructions: _____

Second Pharmacy: _____ Address: _____

Phone: _____ Special Instructions: _____

Advance Beneficiary Notice of Non-Coverage (ABN)

NOTE: If Medicare or your medical insurance does not pay for **certain procedures** listed below, you may have to pay. *Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect that Medicare or insurance will not pay for the following:*

Services	Reason Insurance May Not Pay:	Estimated Cost
CPT code: 92015 Refraction (determines your eye glass or contact prescription)	**If your diagnosis is medical and your vision coverage doesn't cover your medical exam, your insurance may cover the exam but not the refraction. (considered routine vision)**	**$25.00**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the procedure recommended by the doctor.
  Note: If you choose Option 1 or 2, we will help you to use any insurance that you have.

OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the procedure listed above **IF recommended by the doctor**. I may be asked to pay now, but I also want Medicare or my insurance billed for an official decision on payment, which is sent to me as an EOB (explanation of benefits). I understand that if insurance doesn't pay, I am responsible for payment. If money is collected and insurance **does** pay, a refund of any payments I made, less co-pays or deductibles, will be returned to me or left as a credit on my account.

☐ **OPTION 2.** I want the recommended procedure, but do not bill my insurance. I will pay now as I am responsible for payment. **I cannot appeal if Medicare or my insurance is not billed**.

☐ **OPTION 3.** I **DON'T** want the procedure if recommended or ordered by the doctor. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my insurance would pay.**

This notice gives our opinion, not an official insurance decision. If you have other questions on this notice or about insurance billing, please ask one of trained staff members or the administrator.
Signing below means that you have received and understand this notice. You may also request a copy.

Signature:	Date:

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