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

Name: _____

DOB: _____

Bruce D. Gilliland, O.D.
Frank A. Carusone, O.D.
Heather R. West, O.D.

Medical History Questionnaire – please complete this form to the best of your knowledge

MEDICAL HISTORY

- ❑ None
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial fibrillation (irregular heartbeat)
- ❑ Bone Marrow Transplant
- ❑ BPH
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ Hypertension
- ❑ HIV / AIDS
- ❑ Hypercholesterolemia
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Other

MEDICAL SURGERIES

- ❑ None
- ❑ Appendix: Appendectomy
- ❑ Bladder: Cystectomy
- ❑ Breast: Breast Biopsy
- ❑ Breast: Lumpectomy (right / left / both breasts)
- ❑ Breast: Mastectomy (right / left / both breasts)
- ❑ Colon: Colectomy (Cancer Resection / Diverticulitis)
- ❑ Colon: Colonoscopy
- ❑ Gallbladder: Cholecystectomy
- ❑ Heart: Biological Valve Replacement
- ❑ Heart: Coronary Artery Bypass Surgery
- ❑ Heart: Heart Transplant
- ❑ Heart: Mechanical Valve Replacement
- ❑ Heart: PTCA
- ❑ Joint Replacement: Hip (right / left / both)
- ❑ Joint Replacement: Knee (right / left / both)
- ❑ Kidney: Kidney Biopsy
- ❑ Kidney: Kidney Stone Removal
- ❑ Kidney: Kidney Transplant
- ❑ Kidney: Nephrectomy
- ❑ Liver: Hepatectomy
- ❑ Liver: Liver Transplant
- ❑ Liver: Shunt
- ❑ Ovaries: Oophorectomy (Endometriosis / Cancer / Cyst / Tubal Litigation)
- ❑ Pancreas: Pancreatectomy
- ❑ Prostate: Prostatectomy (Prostate Biopsy / Cancer / TURP
- ❑ Rectum: APR
- ❑ Rectum: Low Anterior Resection
- ❑ Skin: Basal Cell Carcinoma
- ❑ Skin: Melanoma
- ❑ Skin: Skin Biopsy
- ❑ Skin: Squamous Cell Carcinoma
- ❑ Spleen: Splenectomy
- ❑ Testicles: Orchiectomy
- ❑ Uterus: Hysterectomy (Fibroids / Uterine Cancer)

_____

_____

_____

_____

EYE HEALTH HISTORY

- ❑ None
- ❑ Conjunctivitis (allergic / bacterial)
- ❑ Blepharitis (right / left / both)
- ❑ Cataract (right / left / both)
- ❑ Contact Lenses
- ❑ Corneal Dystrophy (right / left / both)
- ❑ Diabetic Retinopathy, Background (right / left / both)
- ❑ Diabetic Retinopathy, Proliferative (right / left / both)
- ❑ Dry Eyes
- ❑ Eye Infection (right / left / both)
- ❑ Glasses
- ❑ Glaucoma (right / left / both)
- ❑ Macular Degeneration (right / left / both)
- ❑ Macular ERM (right / left / both)
- ❑ Narrow Angles (right / left / both)
- ❑ Ocular Hypertension (right / left / both)
- ❑ Ophthalmic Migraine
- ❑ Pseudoexfoliation
- ❑ Retinal Tear (right / left / both)
- ❑ Strabismus (right / left / both)
- ❑ PVD (right / left / both)
- ❑ Other

_____
_____

EYE SURGERIES

- ❑ None
- ❑ Blepharoplasty (right / left / both)
- ❑ Cataract Surgery (right / left / both)
- ❑ Corneal Transplant (right / left / both)
- ❑ DSAEK (right / left / both)
- ❑ Eye Muscle Surgery (right / left / both)
- ❑ Intravitreal Injections (right / left / both)
- ❑ LASIK (right / left / both)
- ❑ LPI (right / left / both)
- ❑ LPT (right / left / both)
- ❑ PRK (right / left / both)
- ❑ Ptosis Repair (right / left / both)
- ❑ Punctal Plugs (right / left / both)
- ❑ Strabismus Surgery (right / left / both)
- ❑ Retinal Laser (right / left / both)
- ❑ Trabeculectomy (right / left / both)
- ❑ Tube Shunt (right / left / both)

❑ If eye surgery: which eye was done & when the surgery was performed: _____
_____
_____

Medications _____
_____
_____
_____
_____

Allergies _____
_____
_____

SOCIAL HISTORY

Smoking Status

- ❑ Never Smoke
- ❑ Current every day smoker
- ❑ Former smoker

Drug Status

- ❑ None
- ❑ Drug Use

Alcohol Status

- ❑ None
- ❑ Less than 1 drink per day
- ❑ 1-2 drinks per day

Driving Status

- ❑ Not Driving
- ❑ Drives in daytime
- ❑ Drives at night

Additional Details

- ❑ None
- ❑ I feel safe at home
- ❑ I do not feel safe at home

DEVELOPMENTAL HISTORY – for 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

FAMILY HISTORY	**Mother:**	**Father:**	**Sister:**	**Brother:**	**Grandmother:**	**Grandfather:**	**Aunt:**	**Uncle:**
Arthritis	❑	❑	❑	❑	❑	❑	❑	❑
Blindness	❑	❑	❑	❑	❑	❑	❑	❑
Cataract	❑	❑	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑	❑	❑
Macular Degeneration	❑	❑	❑	❑	❑	❑	❑	❑
Retinal Detachment	❑	❑	❑	❑	❑	❑	❑	❑
Retinitis Pigmentosa	❑	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑	❑	❑
Lupus	❑	❑	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑	❑	❑
Other: _____	❑	❑	❑	❑	❑	❑	❑	❑

_____

_____

If Cancer, please give all details of who & what type _____

_____

_____

_____

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: _____

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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)**	**$45.00**

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:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection.