DATE	INT.

Premier Eyecare of Edmond
Medical History Questionnaire

PATIENT INFORMATION

Name:_____ **Today's Date:** ___/_____/_____

Address:_____ **Birth Date:** ____/____/_____

City:_____ **State:** _____**Zip:**_____ **Home Phone:**_____

Email:_____ **Cell Phone:**_____

Preferred method of contact: (circle) Call Text Email

INSURANCE INFORMATION

Primary Member's Name:_____ **Birth Date:**___/____/_____

Social Security: ___-___-____ _____

Primary Medical Doctor:_____ **City:** _____

MEDICAL HISTORY

Personal/Family History

Please indicate if the patient or any family members have a history of any of the following:

CONDITION	PATIENT	FAMILY	UNSURE		PATIENT	FAMILY	UNSURE
Blindness	☐	☐	☐	Arthritis	☐	☐	☐
Cataracts	☐	☐	☐	Cancer	☐	☐	☐
Glaucoma	☐	☐	☐	Diabetes	☐	☐	☐
Turned Eye	☐	☐	☐	Heart Disease	☐	☐	☐
Macular Degeneration	☐	☐	☐	High Blood Pressure	☐	☐	☐
Eye Injury	☐	☐	☐	Kidney Disease	☐	☐	☐
Eye Surgery	☐	☐	☐	Lupus	☐	☐	☐
Lazy Eye	☐	☐	☐	Thyroid Disease	☐	☐	☐

Other Health Conditions _____

Allergic to medications? (circle) Yes No If yes, explain:_____

List any medications currently taking:_____

ANSWER IF UNDER 18:

Has the child been exposed to Tobacco products, Alcohol or Recreational drugs? (circle) Yes No
If yes explain _____

Was the child born premature? (circle) Yes No **Has the child ever had a seizure? (circle) Yes No**

Is the patient being treated for ADD or ADHD? (circle) Yes No If yes, medication?_____

EYEWEAR HISTORY

Has the patient ever had an eye exam? (circle) Yes No **Date of Last Exam:**_____/____/_____

Name of Eye Doctor _____ **City:** _____

Were glasses or contacts prescribed at this time? (circle) Yes No

If yes, when is correction worn? All the time Reading/Near work Distance/Driving

Is the patient planning on getting new glasses today? Yes No Unsure

Has the patient ever worn contact lenses? Yes No

Is the patient interested in contact lenses today? Yes No Unsure

Does the patient work on a computer more than 4 hours per day? Yes No

CONTINUED ON BACK→

How did you become aware of our practice?

Friend recommendation

Insurance provider

Drove by

Referred by other professional

Other:_____

ASSIGNMENT OF BENEFITS AUTHORIZATION

I understand that I am responsible for the balance on my account for any professional services rendered by Premier Eyecare of Edmond, regardless of my insurance status.
I request that payment of authorized medical or routine vision benefits be made to Premier Eyecare of Edmond on my behalf for any services I receive. I authorize Premier Eyecare of Edmond, LLC to release to my insurance company all information necessary to determine benefits or benefits payable to related services.

Signature_____Date_____

NOTICE OF PRIVACY PRACTICES

(Available at the front desk)

I acknowledge that I have read or have had the opportunity to read Premier Eyecare's Notice of Privacy Practices.

Patient Name_____

Signature_____Date_____