BROOKS EYE CARE

Jordan Brooks O.D.

PATIENT HISTORY QUESTIONNAIRE

Patient Name: _____ **Date**:_____

Circle Yes or No if you have or had any of the following medical conditions and **describe where indicated…**

High Blood Pressure Yes/No Nervous _____ Gastrointestinal _____
High Cholesterol Yes/No Mental _____ Urinary _____
Headaches Yes/No Ear/Nose/Throat _____ Endocrine _____
Asthma Yes/No Respiratory _____ Blood/Lymph _____
Cardiovascular _____ Muscle/Bones _____ Allergenic/Immunologic _____
Integumentary (skin) _____Diabetes Yes/No Type_____Date of Diagnosis_____

Other Health Problems_____
Allergies to Medication? Yes/No Which? _____
_____Reactions_____
Current Medication(s) Check if none □_____
_____
_____
Current Eye Drops Check if none □_____
Have you had any operations? Yes/No Kind? _____
_____When_____
Are you pregnant? Yes/No Breast feeding? Yes/No
Preferred Pharmacy _____ Name of Primary Care Physician_____

Social History

Tobacco Yes/No Alcohol Yes/No Other substances_____

Family History

Diabetes Yes/No Relation _____ Macular Degeneration Yes/No Relation_____
Glaucoma Yes/No Relation_____ Retinal Detachment Yes/No Relation _____
Cataracts Yes/No Relation _____
Other serious eye disease Yes/No Name of condition_____ Relation_____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind?_____
Have you had any eye operations? Yes/No Type_____
Have you had an eye injury? Yes/No Type_____

Glaucoma?	**Yes/No**	**Dry Eyes?**	**Yes/No**
Macular Degeneration?	**Yes/No**	**Blurred Vision?**	**Yes/No**
Retinal Detachment?	**Yes/No**	**Cataracts?**	**Yes/No**

Date of last eye examination _____
Have you seen Dr. Brooks in another office? Yes/No Where?_____
Do you wear glasses? Yes/No Contact Lenses? Yes/No Type_____

Brooks Eye Care

PATIENT INFORMATION

Last Name_____First Name_____MI_____

Mailing Address_____ Apartment #_____

City_____State_____ Zip_____

Secondary/Northern Address_____

City_____State_____Zip_____

Date of Birth_____Employer_____Occupation_____

Cell Phone (___)_____ Home (___)_____ Work (___)_____

SSN _____ E-Mail_____

Emergency Contact Name_____Phone Number (___)_____

How did you hear about Brooks Eye Care? _____

CONTACTING YOU

I authorize Brooks Eye Care to call or text me at the phone number(s) listed above or the numbers we have on record regarding appointment reminders, glasses or contact lens order status and unused vision insurance benefit reminders. **You will only be contacted by Brooks Eye Care, we will not release your phone number to outside sales companies**. This is not required but it makes it much easier for us to contact you. If you wish to not receive these phone messages from us, reply "stop".

☐ **I DO** authorize Brooks Eye Care to message me. ☐ **I DO NOT** authorize Brooks Eye Care to message me.

INSURANCE INFORMATION

Please initial below:

_____ I certify that I (or my dependent) have insurance and/or Medicare coverage, and assign direct payment to Brooks Eye Care for service and material benefits. I authorize the use of this signature on all insurance submissions.

_____ I understand that I am financially responsible for all co-pays, deductibles, materials and services not covered by my insurance and/or Medicare. I authorize Brooks Eye Care to release any information necessary to secure payment of benefits. If Brooks Eye Care does not receive payment from your insurance within 90 days, we may bill you for services preformed.

_____ I have read and understand my HIPPA Rights and Responsibilities, or have been offered a copy to take with me. We keep a copy at the front desk for you to read.

_____ For patients with medical insurance coverage: I understand that most medical insurance (including Medicare) do not cover the refraction (test used to determine the glasses prescription) and that I am responsible for the $50 refraction fee. If you have separate vision insurance that will be billed for a visit, a refraction is covered. If you have medical and vision insurance and your chief complaint is medical in nature, your medical insurance will be billed for the exam and you will be charged for a refraction if preformed.

_____ No show policy: A charge of $50 will be incurred if you no show for a scheduled appointment or if you do not provide us with at least 24 hour notice to cancel an appointment. This charge will need to be paid before you will be allowed to schedule another appointment.

_____ _____

Signature Date