LATIMER VISION CENTER PATIENT HISTORY QUESTIONNAIRE

Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Best Phone _____ Alternate Phone _____ E-mail _____

Date of Birth _____ Age _____ Gender _____ Social Security Number: _____

Occupation _____ Employer _____

Emergency Contact Name _____ Relationship _____ Phone _____

Date of Last Exam _____ Doctor _____

Primary Vision Coverage _____ Secondary Coverage _____

Who is the Primary Insured? _____ Relationship to Patient _____

Primary Insured's Date of Birth _____ Insurance Number _____

Who may we thank for referring you to us? _____

☐ I have received a copy of LATIMER VISION CENTER's Notice of Privacy Practices.

☐ I realize that the Latimer Vision Center is filing my insurance as a courtesy to me. In the event that my insurance does not pay as expected, I will be responsible for any balance due. I fully understand that insurance co-pays and all non-covered fees are due at the time of service. I hereby authorize the doctors of Latimer Vision Center to release all information necessary to secure the payment of benefits. I request that payment of authorized insurance benefits be made either to me or on my behalf to my physician for any services furnished to me by that physician. I authorize the use of this signature on all insurance submissions

_____
Responsible Party Signature

Personal Eye Health Information

What problem(s) brings you in to see us today? _____

_____

Have you had any eye operations? Y / N Type _____ Date _____

Have you had any eye injuries? Y / N Kind _____ Date _____

Glaucoma	Y / N	Cataracts	Y / N	Dry Eyes	Y / N
Macular Degeneration	Y / N	Retinal Detachment	Y / N	Watery Eyes	Y / N
Wear Glasses	Y / N	Contact Lens Related Problems	Y / N	Tired Eyes	Y / N

Do you wear contact lenses? Y / N Type: _____

Additional Ocular Health Information:

Personal Medical Information

Gastrointestinal	Y / N	Nervous	Y / N	Endocrine (glands)	Y / N
Ears/Nose/Throat	Y / N	Urinary	Y / N	Blood / Lymph	Y / N
Cardiovascular	Y / N	Muscles/Bones	Y / N	Allergic / Immunologic	Y / N
Respiratory	Y / N	Integumentary (skin)	Y / N	Headaches	Y / N
High Blood Pressre	Y / N	Eyes	Y / N	Mental	Y / N

Please explain any YES answer: _____

Diabetes Y / N Type: _____ Medication Allergies _____

Other Health Problems _____

Current Medications _____

Please list any surgeries and their approximate dates: _____

Family History

High Blood Pressure	Y / N	Relationship	_____	Macular Degeneration	Y / N	Relationship	_____
Diabetes	Y / N	Relationship	_____	Retinal Detachment	Y / N	Relationship	_____
Glaucoma	Y / N	Relationship	_____	Cataracts	Y / N	Relationship	_____

Doctor Use Only

Reviewed by _____ ☐ No Changes Date _____

Reviewed by _____ ☐ No Changes Date _____

Reviewed by _____ ☐ No Changes Date _____