

Patient History Questionnaire

(Must be updated at each visit)

Email address _____

Last name _____ First name _____ MI _____

Address _____ City _____ Zip _____

Telephone (W) _____ (H) _____ SSN _____ - _____ - _____ DOB ____/____/____

Occupation _____ Employer _____

Emergency Contact _____ Telephone # _____

Date of last eye exam _____ Dilated? _____ Today's date ____/____/____

Medical Information

What is your general health? _____

Do you have problems with any of these systems?

Eyes Y/N Gastrointestinal Y/N Nervous Y/N Mental Y/N

Ears/Nose/Throat Y/N Genitourinary Y/N Endocrine (glands) Y/N

Cardiovascular Y/N Musculoskeletal Y/N Blood / Lymph Y/N

Respiratory Y/N Integumentary (Skin) Y/N Allergic / Immunologic Y/N

Diabetes Y/N Type _____ Date of diagnosis _____

Allergies Y/N Allergic to what? _____ What Happens? _____

Medication Allergy Y/N What Happens? _____

Headaches Y/N

Other Health Problems _____

Current medication(s) _____

Have you had any operations? Y/N Kind? _____ When? _____

Do you use cigarettes/tobacco? _____ Alcohol? _____ Other substance? _____

Name of family doctor _____ Date of last visit _____

Date of last tetanus shot _____

Family History

High blood pressure Y/N Relation _____ Macular Degeneration Y/N Relation _____

Diabetes Y/N Relation _____ Retinal detachment Y/N Relation _____

Glaucoma Y/N Relation _____ Cataracts Y/N Relation _____

Other eye condition(s) Y/N What kind? _____ Relation _____

Personal Eye Information

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

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

Do you have glaucoma? Y/N cataracts? Y/N dry eyes? Y/N blurred vision? Y/N

Other eye problems? Y/N What Kind? _____

Do you wear glasses? Y/N Contact Lenses? Y/N Type _____

Whom may we thank for referring you? _____

Doctors initials _____

Ocotillo Eyecare

Patient Medical Information and Financial Responsibility Form

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

Address: _____

VISION INSURANCE INFORMATION

Vision Insurance Name: _____

Policyholder's Name: _____

Member ID: _____

Date of Birth: _____

Address (If different from patient): _____

MEDICAL INSURANCE INFORMATION

Primary Medical Insurance: _____

Policyholder's Name: _____

Policyholder's Date of Birth: _____

Address (If different from patient): _____

Member ID: _____

Group Number: _____

SECONDARY INSURANCE INFORMATION

Secondary Medical Insurance (If applicable): _____

Policyholder's Name: _____

Policyholder's Date of Birth: _____

Address (If different from patient): _____

Member ID: _____

Group Number: _____

Ocotillo Eyecare is not a provider for all medical insurances. We will submit to your insurance company. In the event that they do not pay, the cost will be the patient's responsibility. In some cases the insurance will only pay a portion of the claim. The remainder will be the responsibility of the patient.

Ocotillo Eyecare is an in-network provider for Aetna, Blue Cross Blue Shield, United Health Care, Medicare, Cigna PPO and OAP. We are in the process of widening our list of insurances.

*By signing patient takes responsibility of any balance on account.

Patient Signature _____

Date _____

PLEASE PRESENT YOUR INSURANCE CARD TO BE COPIED

Ocotillo Eyecare

We at Ocotillo Eyecare are proud to provide our patients with a highly advanced Digital Retinal Photograph Service, which scans the retina to rule out or screen for eye diseases and dramatically improves our ability to view your retinal health.

EARLY DETECTION OF EYE DISEASE IS CRUCIAL

The doctors recommend most patients have Digital Retinal Photography once a year so we can view and record your retina at up to 100 times normal size. With this service you can expect:

- An annual eye wellness screening photograph
- An in depth view of the retinal surface
- A discussion with you and the doctor regarding the images
- A permanent record for your medical file, for year to year comparison and diagnosis
- A quick, easy, comfortable experience
- Typically no dilation drops
- This technology allows the doctors to fully screen for and evaluate retinal problems such as macular degeneration, glaucoma, retinal holes, detachments and diabetic retinopathy all which can lead to partial loss of vision or blindness. Also systemic disease such as diabetes and high blood pressure can be detected during a retinal exam

Insurance is designed to cover a basic exam only. It does not cover advanced procedures such as Digital Retinal Photography. Our doctors recommend this service to our patients. There is an additional \$24.00 charge.

_____ I would like to have my retinal health evaluated with Digital Retinal
_____ Photography.

_____ I DO NOT wish to have Digital Retinal Photography

Patient: _____ Date: _____