JONES EYECARE, PLLC
PATIENT INFORMATION & HISTORY QUESTIONAIRE

Last Name: _____ First Name: _____ MI: ____ Nickname: _____ Salutation: _____

Address: _____ City: _____ ST: ____ Zip: _____ Gender: M F

Telephone: (H)_____ (W)_____ (Cell)_____ Call first? Please circle: Home Work Cell

Email: _____SSN: _____ Date of Birth: _____/_____/_____

Occupation: _____ Employer: _____ How did you hear about us? _____

VISION and MEDICAL INSURANCE ***(Office use only)***

Vision Insurance: _____ ID# _____ Card present/scanned? YES / NO

Primary **Medical** Insurance: _____ ID# _____ Card present/scanned? YES / NO

Secondary **Medical** Insurance: _____ ID# _____ Card present/scanned? YES / NO

REASON FOR VISIT

What Concerns are you having with your Eyes / Vision? _____
Date of Last Eye Exam: _____ Last Eye Doctor: _____
How many hours a day do you use a computer? _____ Digital device? _____
Do you wear contact lenses? YES / NO If so, what brand & power_____
Your insurance requires that we ask: What is your Height_____ Weight_____
Are you allergic to any medication? YES NO If yes, please list: _____
What Medications Are You Currently Taking? (Prescribed, Over-the-Counter, and/or Eye)
_____
_____

Primary Care Physician: _____ Date of Last Visit: _____

Do you use any of the following:	Alcohol	O Yes O No	If yes, frequency: every day / some days / light?
	Tobacco	O Yes O No	If yes, frequency: every day / some days / light?
	Illegal Drugs	O Yes O No	If yes, Explain: _____

REVIEW OF SYSTEMS: Do you currently, or have you ever had problems in the following areas:

Eye	YES	NO
Loss of Vision	____	____
Blurred Vision	____	____
Double Vision	____	____
Eye Injury	____	____
Eye Surgery	____	____
Flashes/Floaters	____	____
Glare/ Halos	____	____
Crossed/lazy eye	____	____
Cataracts	____	____
Glaucoma	____	____
Eye pain/soreness	____	____
Endocrine		
Thyroid	____	____
Ear/Nose/Throat		
Allergies/Hay Fever	____	____
Genitourinary/Hematologic		
Kidney/Bladder/Other	____	____

Vascular/Heart	YES	NO
Diabetes	____	____
Hypertension	____	____
Neurological		
Headaches	____	____
Migraines	____	____
Seizures	____	____
Respiratory		
Asthma	____	____
Chronic Bronchitis	____	____
Emphysema	____	____
Skin Disorders	____	____
Psychiatric	____	____
Bones/Joints/Muscle		
Rheumatoid arthritis	____	____
Joint pain	____	____
Pregnant/Nursing	____	____
Other _____		

FAMILY HISTORY (Circle One)
(F)Father (M)Mother (B)Brother (S)Sister
(S) Son (D) Daughter

Systemic Condition						
Cancer	F	M	B	S	S	D
Diabetes, type I	F	M	B	S	S	D
Diabetes, type II	F	M	B	S	S	D
Hypertension	F	M	B	S	S	D
Thyroid Disorder	F	M	B	S	S	D

Ocular Condition						
Blindness	F	M	B	S	S	D
Crossed Eyes	F	M	B	S	S	D
Glaucoma	F	M	B	S	S	D
Macular Degeneration	F	M	B	S	S	D
Retinal Detachment	F	M	B	S	S	D

PRIVACY - By signing, I attest that I am either the patient being seen or the parent/legal guardian of this minor being seen. I certify that I have read and understood the above information to the best of my knowledge and that I have provided the information as accurately as possible. I understand that providing incorrect information can be dangerous to my health. I give permission for the doctor(s) to examine, diagnose, and initiate treatment as deemed appropriate. I authorize the doctor to release any information including the diagnosis and a summary of any treatment or examination rendered to me or my child to the appropriate third party payers or other health care providers. I authorize and request my insurance company to pay all appropriate benefits directly to the doctor. I understand my insurance carrier may pay less than the actual amount of the fee for services and materials and I agree to be responsible for payment of all uncovered services and supplies rendered on my behalf or my dependents. I authorize the doctor and/or Jones Eyecare, PLLC employees to contact me by phone, email, or written correspondence concerning future eye exams or pertinent eye health issues. I acknowledge that I have been given the opportunity to read a copy of the privacy practices of Jones Eyecare, PLLC.

FINANCIAL POLICY - We appreciate your trust in us and we appreciate the opportunity to serve you. We are committed to providing the highest level of eye care to our patients. To ensure that our patients fully understand our billing process, we ask that you read and sign this financial policy statement.

PATIENT PAYMENTS - Payment is due **at the time of service**. You may use cash, check, credit card, or debit card to pay your account.

INSURANCE COVERAGE - We make a good faith attempt to verify your insurance coverage. We are not able to guarantee that the information given to us by your insurance is correct. It is your responsibility alone to know what insurance plan you are on, supply us with the correct information at the time of your visit and know what services may or may not be covered by your insurance.

INSURANCE PAYMENTS - Regarding insurance, your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We require certain co-payments, deductibles or prepayment amounts depending on the type of insurance and insurance carrier. Be assured our office works diligently to obtain payment from your insurance company**. ESTABLISHED PATIENTS / MISSED / LATE CANCELLED APPOINTMENTS** - Please give us at least *24 working hours* notification if you cannot keep an appointment. This courtesy will allow others to be seen. We do realize that emergencies arise. **RETURNED CHECKS** - Our bank charges us whenever a patient presents a check that does not have funds available. Therefore, we must charge you a $35.00 handling fee. All future visits will need to be paid with either cash or a credit card.

PATIENT AUTHORIZATION

I have read, understand, and agree to abide by the terms stipulated above. I request that payment of benefits be made to Jones Eyecare, PLLC. I hereby authorize the release of any information necessary to determine liability for payment and obtain reimbursement on any claim. I further authorize the use of my signature below on all insurance submissions for services rendered or to be rendered. I agree that a photocopy of this agreement shall be as valid as the original.

I give my permission for the physicians and/or staff of Jones Eyecare, PLLC to release my health information and/or financial information as indicated below:

_____ Information may be left on the home, work, or cellular voicemail requesting that I call the office.

Patient Name _____ **Patient/ Guardian Signature** _____ **Date** _____

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

_____ No, I do NOT give consent to release my information to anyone unless directly specified. (Please initial if declined consent.)

_____YES, I, _____, authorize and request Jones Eyecare, PLLC to release the following information for

_____ (patient name if under 18 years of age) to the individuals listed below. Please check all that apply.

(___) Spectacle, Contact Lens and/or Medication prescriptions (___) Materials Purchased and/or Financial Information (___) All Medical records.

Please list all names that apply and relationship:

(Name)_____ (Relationship) _____
(Name)_____ (Relationship) _____
(Name)_____ (Relationship) _____

I understand that if my medical record contains information concerning HIV (AIDS) or drug or alcohol abuse, those portions of my medical record are protected by state or federal law. I hereby release and forever discharge Jones Eyecare, PLLC, it's physicians and employees, or agents from any liability arising out of the release of my medical record as specified above and pursuant to this signed authorization. This consent is subject to written revocation at any time*, except to the extent that the disclosure has already taken place in reliance on it.

Patient/Guardian Signature: _____Date: _____