SPECTRUM EYE CARE - HISTORY FORM

PATIENT INFO

Name ______________________________ **Date** ____/____/____
First MI Last

Address ______________________________

City/State/Zip ______________________________

Phone (Home)______________________ (Work)______________________

(Cell)______________________ (Other)______________________

DOB ____/____/____ **SS#** ______________________

Occupation ______________________ **Employer** ______________________

Email Address ______________________________

PRIMARY INFO

☐ *Check if Patient IS the Policy Holder for Vision and Medical Insurance.*
*(If checked **only** fill out policy/ID number.)*

Vision Insurance

Primary Policy Holder ______________________ **Primary DOB** ____/____/____

Policy Holder's SS# ______________________ **Policy/ID#** ______________________

Medical Insurance

Primary Policy Holder ______________________ **Primary DOB** ____/____/____

Policy Holder's SS# ______________________ **Policy/ID#** ______________________

1) CIRCLE *Y* OR *N* IF THEY APPLY TO YOU

2) CIRCLE *F* IF THEY APPLY TO FAMILY

Allergic / Immunologic

Environmental allergy	Y	N	F
Rheumatoid Arthritis	Y	N	F
Lupus	Y	N	F

Musculoskeletal

Fibromyalgia	Y	N	F
Muscular dystrophy	Y	N	F
Osteoarthritis	Y	N	F
Ankylosing Spondylitis	Y	N	F

Eyes

Glaucoma	Y	N	F
Cataracts	Y	N	F
Macular Degeneration	Y	N	F
Surgery	Y	N	F
Inflammatory disorders	Y	N	F
Injuries	Y	N	F
Retinal Detachment	Y	N	F
Lazy/crossed eye	Y	N	F

CONTINUED ON BACK...

Cardiovascular

Heart Disease	Y	N	F
High Blood Pressure	Y	N	F
Stroke	Y	N	F
Vascular Disease	Y	N	F
High Cholesterol	Y	N	F
Low Blood Pressure	Y	N	F
Heart Attack	Y	N	F
Congestive Heart Failure	Y	N	F
Irregular Heart beat	Y	N	F
Bypass Surgery	Y	N	F
Fast/Slow Heart Rate	Y	N	F
TIA's	Y	N	F

Gastrointestinal

Crohn's	Y	N	F
Colitis	Y	N	F
Ulcer	Y	N	F
Digestive	Y	N	F

Neurological

MS	Y	N	F
Epilepsy	Y	N	F
Alzheimer's	Y	N	F
Parkinson	Y	N	F
Cerebrovascular	Y	N	F
Seizures	Y	N	F
Concussion	Y	N	F
Migraine	Y	N	F
Blackouts	Y	N	F

General/Systemic

Developmental Disability	Y	N	F
Sudden Weight loss	Y	N	F
Fever	Y	N	F
Fatigue	Y	N	F
Trauma	Y	N	F
Motion Sickness	Y	N	F
Pregnant/Nursing	Y	N	F
Kidney Disease	Y	N	F
Hepatitis	Y	N	F
Jaundice	Y	N	F
Lyme's Disease	Y	N	F
HIV/AIDS	Y	N	F
Cancer	Y	N	F
Tumor	Y	N	F
Had a CT or MRI	Y	N	F
Learning Disorders	Y	N	F
ADD/ADHD	Y	N	F
Autism Spectral Disorder	Y	N	F
MRSA	Y	N	F
Disabilities	Y	N	F

Genitourinary

STD	Y	N	F
Viral Herpetic	Y	N	F
Chlamydia	Y	N	F

Psychiatric

Depression	Y	N	F
Panic disorder	Y	N	F
Schizophrenia	Y	N	F
Anxiety	Y	N	F

Ear, Nose, Mouth & Throat

Upper Respiratory infection	Y	N	F
Ear ache	Y	N	F
Runny nose	Y	N	F
Sore Throat	Y	N	F
Ringing-Tinnitis vertigo	Y	N	F

Hematologic / Lymphatic

Anemia	Y	N	F
Large Volume Blood loss	Y	N	F
Leukemia	Y	N	F
Bleeding problems	Y	N	F
Sickle Cell	Y	N	F

Respiratory

Asthma	Y	N	F
Bronchitis	Y	N	F
Emphysema	Y	N	F
Ever Smoke?	Y	N	F
Still Smoke?	Y	N	F
Pneumonia	Y	N	F
Sleep Apnea	Y	N	F
COPD	Y	N	F
Chronic Cough	Y	N	F
TB	Y	N	F
Shortness of Breath	Y	N	F

Endocrine

Diabetes	Y	N	F
Thyroid Dysfunction	Y	N	F
Hormonal Dysfunction	Y	N	F
Low Blood Sugar	Y	N	F

Integumentary

Eczema	Y	N	F
Rosacea	Y	N	F
Psoriasis	Y	N	F

Please list any MEDICATIONS you take (include aspirin, birth control, hormones & vitamins):

Please list things you are ALLERGIC TO (medications, seasonal, food):

- ***If paying by check, please make check payable to: Spectrum Eye Care***
- ***Exam fees are due at the time of service and non-refundable.***
- *Patients are accountable for understanding their insurance fees, coverage and co-pays. Any fees not covered by the insurance will be the responsibility of the patient/guardian/parent. Any questions or doubts regarding dues will be answered by the respective insurance company.*

See Back Side

HIPAA PRIVACY ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____ [Please print full legal name here] (the "Patient" or " Patient's legal representative), have been presented with the Notice of Privacy Policy (the "policy") of Scott Sander, OD, (in the notebook) and have been offered a copy of such policy to keep for my records (other copies available).

____ ________________________

Signature of Patient / Parent / Legal Representative Date

FOR OFFICE USE ONLY

I, ______________________________, [Please print full legal name here], acting as ____________________[Please print relationship to or official position with Provider] for provider attempted to obtain the written acknowledgement of receipt of the Policy of Provider on __________________ [date attempt was made], but acknowledge could not be obtained because:

__________ [Please initial here] Patient or Patient's legal representative refused to sign.

__________]Please initial here] Patient or Patient's legal representative could not be communicated with sufficient to obtain acknowledgement.

__________ [Please initial here] Emergency circumstances prevented securing acknowledgement.

__________ [Please initial here] Other {please specify}____

See Back Side