Mr / Mrs / Ms / Dr

Patient History Form

Today's Date ____ /____/_________

Patient Name: ______________________________ Date of Birth ____/____/_________

Address: ______________________ City: ____________________ State: _________ Zip: ___________

Cell Phone: (____) _______________________ Other: (____) _______________________

Occupation: ____________________ Employer: ________________________ Last Eye Exam: _______________

Eyes ever been dilated: □ Yes (~ Year ______) □ No

Email Address: _________________________ Referred by/Heard about us from: ______________________

Insurance Information

Name of **VISION** Plan: __________________________

Policy Holder's Name: __________________________

Policy Holder's Date of Birth: ____________________

Relationship to Insured: □ Self □ Spouse □ Dependent

Policy Holder's ID or SS#: _______________________

Name of **MEDICAL** Plan: __________________________

Policy Holder's Name: __________________________

Policy Holder's Date of Birth: ____________________

Relationship to Insured: □ Self □ Spouse □ Dependent

Policy Holder's ID or SS#: _______________________

Medical Conditions/Review of Systems: Do YOU currently have or have YOU ever had (if so, when?) any diagnoses in the following areas?

CIRCLE all that apply:

CONSTITUTIONAL: other/add'l info
Developmental Disabilities, Cancer, Fatigue, ________________

ENT (Ears, Nose, Throat):
Hearing loss, sinusitis, dry mouth, laryngitis, ________________

NEUROLOGICAL:
MS, Epilepsy, CP, Tumor, Stroke/CVA, Migraine, Autism, _______

PSYCHIATRIC:
Depression, ADD/ADHD, Anxiety, Bipolar, ________________

CARDIOVASCULAR:
Hypertension, Stroke, Heart Disease, Vascular Disease, CHF, _____

RESPIRATORY:
Cigarette smoker, Asthma, COPD, Sleep apnea, ______________

GASTROINTESTINAL/GENITOURINARY: other/add'l info
Crohn's, Colitis, Ulcer, Acid Reflux, Celiac, ____________________
Kidney disease, Prostate, STD, currently Pregnant/Nursing __________

MUSCULOSKELETAL:
Osteoarthritis, Fibromyalgia, MD, AS, Osteoporosis, Gout, __________

INTEGUMENTARY (skin):
Eczema, Rosacea, Herpes zoster/shingles, Herpes Simplex/Cold Sores

ENDOCRINE:
Type 2 Diabetes, Type 1 Diabetes, Thyroid, Hormonal, ____________

HEMOTOLOGIC/LYMPHATIC:
Anemia, Ulcer, High Cholesterol, Other ______________________

ALLERGIC/IMMUNE:
Environmental Allergies, Rheumatoid Arthritis, Lupus, Sjogren's, _____

***PRIMARY CARE DOCTOR:**
Name/Address/Clinic Name:____

LIST ANY MEDICATIONS (AND DOSAGES) you take (include over-the-counter medicine, **eye drops**, vitamins and supplements):

____

____

____

Do you have any allergies to medications: Y N If yes, list/explain________________________________

Ocular/Eye/Vision Review of Systems:

Do YOU currently have?			**Have YOU ever had?**		
Blurred Vision	Y	N	Eye Infection(s)	Y	N
Dry Eyes	Y	N	Glaucoma (or suspect)	Y	N
Itchy Eyes	Y	N	Cataracts	Y	N
Eye Discharge	Y	N	Macular Degeneration	Y	N
Tearing	Y	N	Retinal Detachment	Y	N
Floating Spots	Y	N	Lazy Eye	Y	N
Flashing Lights	Y	N	Eye Surgery	Y	N
			Dry Eye	Y	N

Details:____

____

Contact Lens Questions:

Are you interested in contact lenses?	Y	N
Have you ever worn contacts?	Y	N
Do you now wear contacts?	Y	N
What type? ______________________		
How long have you had this pair? ______________		
Do you sleep in your contacts?	Y	N
Are you happy with your current lenses?	Y	N
Feel dry/irritated with your current brand?	Y	N
Are you interested in trying a new lens?	Y	N
Are you interested in Laser Eye Surgery?	Y	N

Family History: Please note any **immediate family members (parents, siblings, children)** with any of these conditions:

Cancer	Y	N	Who: ______		Cataracts	Y	N	Who: _____
Diabetes	Y	N	Who: ______	Type 1 or 2	Macular Degeneration	Y	N	Who: _____
Hypertension	Y	N	Who: ______		Glaucoma	Y	N	Who: _____
Thyroid	Y	N	Who: ______	Hyper or Hypo	Blindness	Y	N	Who/Cause: ___________

HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rules
Acknowledgement of Receipt

I acknowledge that I have been presented with the Notice of Privacy Policy of Dr. John J. Novak & Dr. Brooke A. Bader and have been offered a copy of such policy to keep for my records.

X ____ __________
Signature of patient (or parent/guardian if under 18) Date

Policies

Contact Lens Wearers Agreement:

Contact lenses are medical devices approved and regulated by the FDA. They can only be dispensed by prescription. They must be regarded with the same caution you would use for prescription drugs. This includes prescription expiration dates and follow-up visits with your optometrist. Progress visits or follow-ups may be required before finalizing the contact lens prescription. If you are experiencing any fitting problems with the contact lenses, schedule a follow-up immediately. All fitting evaluations and follow-ups are included in the exam fee for up to 60 days. After 60 days, there will be an office fee for the visit. Any red eye condition is considered a medical office visit and does not fall under the contact lens fitting or follow-ups. By state law contact lens prescriptions are valid for 12 months and therefore require annual examinations.

Your eyes go through gradual changes in size, shape, and physiological requirements (such as oxygen), and this can change the fit of the contact lenses and affect corneal health. By accepting this agreement, you understand the importance of providing the proper management and replacement of the contact lenses as recommended by the FDA.

Professional Services (Eye exams and evaluations) Agreement:

As with all professional services, there are no refunds on professional fees. The doctor and staff time cannot be refunded. Patients are financially responsible for all services provided. If vision or medical insurance is involved, patients are financially responsible for all deductibles, co-payments, and non-covered services provided. If an insurance authorization is not obtainable, or a claim is denied/not paid within 30 days of submission, patients are financially responsible for the services provided and will be billed appropriately. Non-payment of billed services will be submitted for further action.

DR. JOHN J. NOVAK & DR. BROOKE A. BADER
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