MEDICAL HISTORY

Patient Full Name: _____ **Date:**_____/_____/_____

Address: _____ **Phone:**_____

City:_____ **State:**_____ **Zip:**_____ **Work:**_____

Patients Date of Birth: _____/_____/_____ **(Please circle) Male/Female** **Cell:** _____

Social Security Number: _____ **Last Eye Exam** _____/_____/_____

Employer: _____ **Occupation:** _____

Email address: _____ **Marital Status:**_____

Who referred you to our office? _____ **Race:** _____

How would you like to be contacted for your recall? Mail Phone Email **Preferred Language: English Spanish Other**

Guarantor (Person responsible for account): _____

Guarantor Social Security Number: _____ **Guarantor Date of Birth:** _____/ _____/ _____

Do you have vision insurance? □ No □ Yes If yes, Insurance carrier _____

Name of primary insured: _____**Primary insured's Date of Birth** _____

Primary Insured's SS#: _____**Relationship to insured:**_____

Do you have medical insurance? □ No □ Yes If yes, Insurance Carrier: _____

Name of primary insured: _____**Primary insured's Date of Birth** _____

Primary Insured's SS#:_____**Relationship to insured:** _____

MEDICAL HISTORY

Do you have any allergies to medication? □ No □ Yes If yes, explain_____
_____

List medications you take (including oral contraceptives, aspirin, and over the counter medications, and home remedies)

_____
_____
_____

List all major injuries, surgeries, and/or hospitalizations you have had

_____
_____
_____

List any of the following that you have had – crossed eyes, lazy eye, drooping eyelid, glaucoma, cataracts, retinal disease, eye infections or eye injury:

_____

Are you pregnant or nursing? □ No □ Yes

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease / Condition	No	Yes	?	Relationship
Blindness	□	□	□	_____
Cataract	□	□	□	_____
Crossed Eyes	□	□	□	_____
Glaucoma	□	□	□	_____
Macular Degeneration	□	□	□	_____
Retinal Detachment/Disease	□	□	□	_____
Arthritis	□	□	□	_____
Cancer	□	□	□	_____
Diabetes	□	□	□	_____
Heart Disease	□	□	□	_____
High Blood Pressure	□	□	□	_____
Kidney Disease	□	□	□	_____
Lupus	□	□	□	_____
Thyroid Disease	□	□	□	_____

Circle the answer that applies: Is your exam today for contact lenses, eyeglasses, or both?
Do you wear glasses? □ No □ Yes If yes, how old is your present pair of lenses? _____
Do you wear contact lenses? □ No □ Yes Have you used contacts in the past 12 months? □ No □ Yes
Type of lenses: □ Rigid □ Soft □ Extended Wear □ Other

SOCIAL HISTORY – This information is kept strictly confidential. However, you may discuss this directly with the doctor if you prefer.
□ Yes, I prefer to discuss my social history information directly with the doctor.

Do you drive? □ No □ Yes If yes, do you have visual difficulty when driving? □ No □ Yes If yes, please describe:
_____
_____

Do you use tobacco products? □ No □Yes If yes, type/amount/how long? Have you used tobacco in the past? □ No □Yes
_____
Do you drink alcohol? □ No □ Yes If yes, do you drink alcohol daily, or socially?
_____
Do you use illegal drugs? □ No □ Yes If yes, type/amount/ how long?
_____
Have you ever been exposed to or infected with: □ Gonorrhea □Hepatitis □ HIV □Syphilis

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REVIEW OF SYSTEMS

Do you currently have, or have ever had, any problems in the following areas:

Constitutional	No	Yes	?
Fever, Weight loss/gain	□	□	□
Integumentary			
Skin	□	□	□
Neurological			
Headaches	□	□	□
Migraines	□	□	□
Seizures	□	□	□
Eyes			
Loss of Vision	□	□	□
Blurred Vision	□	□	□
Distorted Vision/Halos	□	□	□
Loss of side vision	□	□	□
Double vision	□	□	□
Dryness	□	□	□
Mucous Discharge	□	□	□
Redness	□	□	□
Sandy or Gritty Feeling	□	□	□
Itching	□	□	□
Burning	□	□	□
Foreign Body Sensation	□	□	□
Excess Tearing/Watering	□	□	□
Glare/Light Sensitivity	□	□	□
Eye Pain or Soreness	□	□	□
Chronic Infection of Eyelid	□	□	□
Sties or Chalazion	□	□	□
Flashes/Floaters in Vision	□	□	□
Tired Eyes	□	□	□
Genitourinary			
Genitals/Kidney/Bladder	□	□	□

Ear, nose, mouth, throat	No	Yes	?
Allergies/Hay fever	□	□	□
Sinus Congestion	□	□	□
Runny Nose	□	□	□
Post Nasal Drip	□	□	□
Chronic Cough	□	□	□
Dry Throat/Mouth	□	□	□
Respiratory			
Asthma	□	□	□
Chronic Bronchitis	□	□	□
Emphysema	□	□	□
Vascular/Cardiovascular			
Heart Pain	□	□	□
High Cholesterol	□	□	□
High Blood Pressure	□	□	□
Vascular Disease	□	□	□
Gastrointestinal			
Chronic Diarrhea	□	□	□
Chronic Constipation	□	□	□
Endocrine			
Thyroid/ Other Glands	□	□	□
Diabetic	□	□	□
Bones/Joints/Muscles			
Rheumatoid Arthritis	□	□	□
Muscle Pain	□	□	□
Joint Pain	□	□	□
Lymphatic/Hematologic			
Anemia	□	□	□
Bleeding Problems	□	□	□
Allergic/ Immunologic	□	□	□
Psychiatric	□	□	□

If you answered yes to any of the above, or have a condition not listed, please explain and list medications:
_____
_____

FINANCIAL POLICY & NON-COVERED SERVICES

1. Payments for all professional services are due at the time services are rendered. This is inclusive of any co-pays, co-insurance, deductible, contact lens evaluation fees, and non-covered charges.

2. We accept most vision insurance policies. Patients with vision insurance must take care of their estimated portion not covered by the insurance at the time of treatment. If payment has not been received from the insurance company within sixty days of the original filing, the patient will be asked to pay the balance due and pursue reimbursement from their carrier.

3. The FDA (Food & Drug Administration) considers contact lenses to be medical devices; consequently, they are regulated by prescription laws similar to that of prescription medications. Accordingly, Professional Standards of Care dictates that all patients who wear contact lenses should have a comprehensive eye examination **and** a corneal/contact lens evaluation at least once yearly. Contact lens services are separate and distinct from a general, comprehensive examination which yields a spectacle prescription. The contact lens evaluation **must** be performed **in addition** to your exam, regardless of whether or not you have a change in your contact lens prescription. **The fee for the corneal/contact lens evaluation must be paid at the time of service and is not filed to your vision insurance.** This service includes two contact lens follow-up visits within 90 days of the date of your eye exam. After the 90 days, additional fees are applicable. You are entitled to a copy of your contact lens prescription but we will not write a prescription or dispense contacts without a yearly comprehensive contact lens examination. Your contact lens prescription will expire one year from the exam date. **Contact lens trials are dispensed at your yearly comprehensive eye exam only.** We recommend that you re-order your contact lenses before your supply runs out, or schedule your yearly eye exam so that you are not without contact lenses.

   If a supply of contact lenses is ordered at the patient's request, the patient has 60 days from the date ordered to return for credit. If the patient does not pick up the supply, or changes his/her mind about purchasing the contacts from The Optical Shoppe, a $4 re-stocking fee will be owed by the patient. Once contact lens boxes are opened, they are deemed non-returnable since contacts are considered by the FDA to be a medical device.

4. We accept cash, checks, or credit cards. A service charge of $40.00 will be accessed on all returned checks. If returned checks are not paid along with the $40.00 service charge within 15 days of the patient being notified, the returned check will be turned over to the Rankin County District Attorney Bad Check Unit for collection.

5. **The office requires the patient to give at least a 24 hour notice of any appointment that needs to be rescheduled or cancelled. We will not allow you to reschedule an additional appointment if your first appointment was broken without proper notification. If you do not show up for any appointment, we reserve the right not to reschedule. M H Allen LLC dba The Optical Shoppe will access a $35.00 fee for any missed appointment.**

6. The office will assess account balances in excess of 90 days and a monthly service charge of one and a half percent (1.5% per month) of the unpaid balance. In the case of an account balance in excess of 90 days, we reserve the right to turn you over to collections. If this situation occurs, you are responsible for paying the unpaid balance plus any collection fees and expenses that are incurred. It is the responsibility of the patient/guarantor to update address and phone number changes in order to stay in direct communication regarding account balances.

Patient Acknowledgment of Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice of Privacy Practices before signing this acknowledgment. Please review the laminated copy given to you at the time of your first visit.

As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by requesting a copy in writing from:

Privacy Officer

MH Allen LLC DBA The Optical Shoppe

4810 Lakeland Dr.

Flowood, MS 39232

By signing this form, you acknowledge that you have reviewed our Notice of Privacy Practices, and have no further questions regarding this form.

Patient or Responsible Party:

Signature: _____ **Date:** _____

PLEASE READ AND SIGN THE ACKNOWLEDGEMENT OF THE FINANCIAL STATEMENT AND RELEASE OF INFORMATION

I hereby give consent to disclose my medical records, and/or pick up prescriptions on my behalf, to the following family member(s) and/or friend(s) listed below:

Name and DOB: _____Phone number: _____

Name and DOB: _____Phone number: _____

Name and DOB: _____Phone number: _____

*I authorize The Optical Shoppe to release any information relating to an illness, injury, diagnosis or care of treatment to my insurance company, health plan or third party payer for any claim related information. Such information shall include, but is not limited to, any medical records and medical information. I understand that the reason for furnishing such information may include the following: for use in medical, financial and/or provider auditing or such other auditing as may be legally required for utilization and/or quality of care review and assessment and of determining available health benefits and coverage.

*I attest I have disclosed all active insurance and agree the proper information is on file with my provider. I understand The Optical Shoppe will file my insurance and I am responsible for any co-pays, co-insurance, deductible, contact lens evaluation fees, and non-covered charges.

Signature: _____ **Date:** _____