FAMILY VISION CARE
JESSICA NISEWONGER, OD

Patient History Questionnaire

Full Name:_____ Birth Date:____/____/____

Address:_____ Social Security #: _____

_____ Home Phone: _____

Email Address:_____ Cell Phone: _____

Occupation:_____ Work Phone: _____

Primary Care Doctor:_____ Last Medical Exam:____/____/____

Previous Eye Doctor (if not us):_____ Last Eye Exam:____/____/____

Responsible Party if different:_____ **Relationship to Patient:** _____

Phone:_____ **Billing Address if different:** _____

EMERGENCY CONTACT NAME:_____ **PHONE:**_____

★ ***PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED, INCLUDING DEDUCTIBLES IF APPLICABLE*** ★

OCULAR HISTORY

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ☐ No ☐ Yes If yes, what type? ☐ Rigid ☐ Soft ☐ Toric ☐ Multifocal ☐ MonovIsion

☐ Extended Wear Do you wear them ☐ Full Time ☐ Part Time How frequently do you replace them? _____

Have you had refractive surgery?_____ If yes, Date_____ Type _____

Are you having any visual difficulties?_____ If yes, please explain: _____

_____

Are you currently experiencing any of the following problems with your eyes? **Check the box if "Yes."**

☐ Blurred Vision	☐ Flashes / Floaters in Vision	☐ Redness
☐ Loss of Vision	☐ Halos / Glare / Light Sensitivity	☐ Excess Tearing / Watering
☐ Loss of Side Vision	☐ Dryness	☐ Eye Pain or Soreness
☐ Distorted Vision	☐ Sandy or Gritty Feeling	☐ Mucous Discharge
☐ Double Vision	☐ Burning	☐ Inflammation of the Eyelid
☐ Tired Eyes	☐ Itching	☐ Styes or Chalazion

Have you been diagnosed with any of the following ocular problems? **Check the box if "Yes."**

☐ Cataracts	☐ Glaucoma	☐ Retinal Detachment / Disease
☐ Crossed Eyes	☐ Lazy Eye / Amblyopia	☐ Dry Eye
☐ Eye Injury	☐ Macular Degeneration	☐ Other _____

MEDICAL HISTORY

List any medications you are currently taking (include oral contraceptives, aspirin, over the counter medications):

_____

_____

_____

Are you allergic to any medications? ☐ No ☐ Yes If yes, which ones: _____

List all major surgeries and/or hospitalizations you have had: _____

_____

REVIEW OF SYSTEMS

Please check the box beside any problem you currently have, or have had, in the following areas:

ALLERGIC / IMMUNOLOGIC ☐ All Normal
- ☐ Allergy / Hay Fever

CARDIOVASCULAR / CARDIAC ☐ All Normal
- ☐ Arteriosclerosis
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol

CONSTITUTIONAL ☐ All Normal
- ☐ Fever
- ☐ Weight Loss / Gain

EARS, NOSE, MOUTH, THROAT ☐ All Normal
- ☐ Sinus Congestion
- ☐ Dry Throat / Mouth

ENDOCRINE ☐ All Normal
- ☐ Diabetes
- ☐ Throid Disease
- ☐ Chronic Fatigue

GASTROINTESTINAL ☐ All Normal
- ☐ Diarrhea / Constipation
- ☐ IBS / Crohn's Disease
- ☐ Ulcers
- ☐ Reflux

GENITOURINARY ☐ All Normal
- ☐ Kidney Disease
- ☐ Ovarian / Uterine Cancer
- ☐ Prostate Cancer

HEMATOLOGIC / LYMPHATIC ☐ All Normal
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Breast Cancer

INTEGUMENTARY (Skin) ☐ All Normal
- ☐ Cancer
- ☐ Rashes
- ☐ Easy Bruising

MUSCULOSKELETAL ☐ All Normal
- ☐ Rheumatoid Arthritis
- ☐ Muscle Pain
- ☐ Joint Pain

NEUROLOGICAL ☐ All Normal
- ☐ Migraines
- ☐ Dizziness
- ☐ Seizures
- ☐ Stroke

PSYCHIATRIC ☐ All Normal
- ☐ Anxiety
- ☐ Depression
- ☐ Memory Loss
- ☐ Hallucinations

RESPIRATORY ☐ All Normal
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Cough

If you checked any of the above boxes or have a condition not listed, please explain further: _____

_____

_____

Are you pregnant and / or nursing? ☐ No ☐ Yes

FAMILY HISTORY

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

	RELATION TO YOU		RELATION TO YOU
☐ Glaucoma	_____	☐ Diabetes	_____
☐ Cataract	_____	☐ Cancer	_____
☐ Macular Degeneration	_____	☐ Heart Disease	_____
☐ Retinal Detachment	_____	☐ High Blood Pressure	_____
☐ Blindness	_____	☐ Kidney Disease	_____
☐ Crossed Eyes	_____	☐ Lupus / Arthritis	_____

Signature: _____ Date ____ / ____ / ____

FAMILY VISION CARE

JESSICA GRIMES, OD

Vision Plans vs. Medical Insurance

We frequently have patients who have both vision plans AND major medical coverage. They differ greatly in the services that they cover, and we feel it is very important for our patients to understand those differences.

Vision plans are used to determine a prescription for glasses and/or contact lenses and sometimes, will help cover the costs of those materials. Vision plans are not designed or equipped to deal with medical conditions, diagnoses, and/or treatment plans of those conditions.

When a medical diagnosis or condition is present (such as diabetes, or eye conditions such as pink eye, "allergy eyes", cataracts or glaucoma — these are only a few examples) it is necessary to file your visit through your major medical carrier — those copays will then apply. Vision plans DO NOT cover medical problems, just as medical insurance doesn't cover routine vision issues. Our office does not make these rules; they are defined by the insurance companies themselves.

There is sometimes no way to know prior to your exam which plan we will be filing. We make every effort to be a provider for all of the major medical carriers in the area (there are a couple currently that will not allow us their panels) and we will file to those carriers when appropriate. In the event that we are not on the panel of your major medical plan, we will give you the required documents so you may try to file for reimbursement.

If you have any questions, please let us know.

I understand the above and authorize Family Vision Care to file my exam with my major medical carrier, if appropriate.

_____

Printed Name of Patient

_____ _____

Signature of Patient or Parent/Guardian Date

FAMILY VISION CARE

JESSICA GRIMES, OD

Consent of Treatment, Billing, and Notice of Privacy Practices

l. I, the undersigned, authorize Jessica A. Grimes, O.D., LLC (Family Vision Care) to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such eye care to third party payers and other health practitioners involved in my care. I authorize and request my insurance company or vision plan to pay directly to Jessica A. Grimes, O.D., LLC all benefits otherwise payable to me for services rendered and/or materials provided. I understand that my vision or medical insurance carrier may pay less than the actual bill for services. In the event it becomes necessary to collect a balance through litigation or a collection agency, I agree to pay all collection fees and attorney's fees incurred. I further authorize the use of this signature on all insurance submissions.

2. I understand that Jessica A. Grimes, O.D., LLC (Family Vision Care) will bill services rendered and/or materials provided to my vision plan and/or medical insurance plan. The appropriate plan to be billed is dependent on the entering complaint, the diagnosis, and the presence of any preexisting medical conditions. I understand that I will be informed of which plan will be billed, and I understand that I am responsible for the copays and/or deductibles that apply to that plan.

3. We can now send text messages concerning your health and account information directly to your mobile device. Text messaging is not secure and could be viewed by third parties. We need your permission to text with you about your health/account. OPT IN _____ / OPT OUT _____

4. Effective May 18, 2022 patients who fails to show or cancels an appointment and has not contacted our office with at least 24 hours' notice will be considered a No Show and charged a $50.00 fee.

I acknowledge that I have been provided with a copy of the Notice of Privacy Practices of Jessica A. Grimes, O.D., LLC (Family Vision Care), effective 5/1/2020.

_____

Printed Name of Patient

_____ _____

Signature of Patient or Parent/Guardian Date