Ferrer Garcia Eyecare - Patient Medical History Date: _____

Name: _____

Address: _____

_____

Tel: (_____)_____ Type: Home / Mobile

Email: _____

Birthdate: ____/_____/____ SSN: _____

Sex: M / F Country of Origin: _____

Primary Doctor and Phone:

_____

When was your last medical exam? _____

Are you experiencing any of the following?

- ☐ Red Eyes
- ☐ Itching
- ☐ Burning
- ☐ Tearing
- ☐ Sandiness
- ☐ Dry Eyes
- ☐ Floaters/spots
- ☐ Flashes of light
- ☐ Eye pain
- ☐ Light Sensitivity
- ☐ Double Vision
- ☐ Eye fatigue/strain

When was your last eye exam? _____

Do you have seasonal allergies? Yes / No

Have you ever been diagnosed with the following?

Cataracts.....☐ Yes	Glaucoma.....☐ Yes
Macular Degeneration.....☐ Yes	Retinal Detachment.....☐ Yes
Strabismus.....☐ Yes	Amblyopia.....☐ Yes
Diabetes.....☐ Yes	Stroke.....☐ Yes
Blood Pressure....☐ Yes	Heart Disease.....☐ Yes
Cholesterol.....☐ Yes	Thyroid.....☐ Yes
Asthma.....☐ Yes	Sinusitis.....☐ Yes
Rheumatoid Arthritis.....☐ Yes	Osteoporosis.....☐ Yes
Anemia.....☐ Yes	Cancer.....☐ Yes
Gastritis.....☐ Yes	Kidney Disease....☐ Yes
Depression.....☐ Yes	Multiple Sclerosis☐ Yes
Migraines.....☐ Yes	Rosacea.....☐ Yes
	HIV.....☐ Yes

Current Medications:

_____

_____

_____

Allergies to Medications: _____

Preferred Pharmacy and Phone:

_____

List prior surgeries(and dates) if any (e.g. LASIK)

_____

_____

Are you pregnant or nursing? Yes / No

Do you smoke? Yes / No Cigs per day: _____

Do you drink? Yes / No Drinks per day: _____

Do you have any family members that attend this office? Please list their name and relationship:

_____

_____

Do you have a family relative that has/has had any of the following? Please indicate family members.

Glaucoma.....☐ Yes	Relation:_____
Macular Degeneration.....☐ Yes	Relation:_____
Diabetes.....☐ Yes	Relation:_____
Blood Pressure..☐ Yes	Relation:_____
Cholesterol.....☐ Yes	Relation:_____
Stroke.....☐ Yes	Relation:_____
Heart Disease....☐ Yes	Relation:_____
Thyroid.....☐ Yes	Relation:_____
Cancer.....☐ Yes	Relation:_____

Visual Needs Assessment:

Occupation: _____

Do you wear contact lenses? Yes / No

Do you use sunglasses? Yes / No

Do you drive? Yes / No

Digital device usage per day : _____ hours

Sports/hobbies: _____

Notice of Privacy Practices Patient Acknowledgment Date: _____

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a complete description of the uses and disclosures of my health information. I understand that Ferrer Garcia Eyecare has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Guardian Name (if applicable): _____

Signature: _____ Relationship to patient (if signed by guardian): _____

No Show/Cancellation Policy:

Ferrer Garcia Eyecare reserves the right to institute a formal policy regarding cancellations and "no shows". A "no show" is defined as a scheduled appointment that the patient fails to keep. Patients are expected to confirm their appointments via call, text, or e-mail. If we do not receive a confirmation 48 hours prior to your scheduled appointment time, **your appointment will be canceled**. A fee of **$45** applies to a confirmed appointment that the patient fails to keep. **I certify that I understand that I am responsible for any fees charged according to this policy and that the office reserves the right to deny further scheduling if I refuse to comply with this policy.**

Signature: _____

Payment Policy:

I hereby assign all medical benefits, including all major benefits to which I am entitled including Medicare, private insurance and any other health plans, to Ferrer Garcia Eyecare. I hereby authorize said assignee to release all information necessary to secure the payment. If my insurance company has not reimbursed Ferrer Garcia Eyecare within 60 days, I may be billed for any services or products that I have received. I understand that I am responsible for the balances due after billing. **I certify that I understand that there are no refunds or exchanges and that all sales are final unless covered under manufacturer warranty or office warranty programs.**

Signature: _____

With patient consent, the office is allowed to retrieve your prescription history, if available, to reconcile your medications. To opt out, please let one of our staff members know.