BIERMANN EYE HEALTH
A MEMBER OF Moorfields Eye Hospital

PATIENT HISTORY QUESTIONNAIRE

Today's date _____

Last Name _____ First Name _____ MI _____ Nickname _____

Address _____ City _____ State _____ Zip _____

Primary Phone _____ (Home / Cell / Work) Secondary Phone _____ (Home / Cell / Work)

☐ I allow Biermann Eye Health to send an appointment reminder via email or text message.

Email address _____ Marital status _____

Date of Birth _____ Sex _____ Social Security Number _____

Occupation _____ Employer _____

Emergency Contact Name _____ Phone Number _____ Relationship _____

Name of family doctor and/or primary care physician _____ Phone number _____

MEDICAL INFORMATION

How is your general health? _____

Tobacco Use: ☐ Never smoked If you have quit, at what age? ____ Average packs/day? ____ At what age did you start? ____

Alcohol Use: ☐ None What is your weekly intake? _____

Do you take medications for any of these systems? **(Please circle yes or no)**

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (Skin)	Yes/No	Headaches	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain _____

Diabetes? Yes ☐ No ☐ Type _____ Date of diagnosis _____

Allergies to medication? Yes ☐ No ☐ Which? _____ Reactions? _____

Other health problems _____

Current medication(s) _____

_____

Have you had any surgeries? Yes ☐ No ☐ Kind? _____ Date _____

_____

FAMILY HISTORY

High blood pressure	Yes/No	Relation _____	Macular degeneration	Yes/No	Relation _____
Diabetes	Yes/No	Relation _____	Retinal detachment	Yes/No	Relation _____
Glaucoma	Yes/No	Relation _____	Cataracts	Yes/No	Relation _____

PERSONAL EYE INFORMATION

Do you have any eye conditions or problems? Yes ☐ No ☐ What kind? _____

Have you had any eye surgeries? Yes ☐ No ☐ Type _____ Date _____

Have you had an eye injury? Yes ☐ No ☐ Type _____ Date _____

Do you have glaucoma?	Yes/No	Cataracts?	Yes/No	Dry eyes?	Yes/No
Macular degeneration?	Yes/No	Retinal detachment?	Yes/No	Blurred vision?	Yes/No
Do you wear glasses?	Yes/No	Contact lenses?	Yes/No	Type _____	

BIERMANN EYE HEALTH
A MEMBER OF Visionary Eyecare

FINANCIAL RESPONSIBILITY & PRIVACY PRACTICES

FINANCIAL RESPONSIBILITY

I authorize the release of medical and financial information for the purpose of collection of my account.

If your doctor is a participating provider with my insurance plan, I authorize my insurance benefits to be paid directly to the doctor and **acknowledge that I am financially responsible for any unpaid balance. I agree to pay this balance in full.** I am aware that my insurance carrier may require me to use participating providers and to follow plan requirements, including primary care referral and/or precertification, and that failure to comply could result in my sole responsibility to pay any charges for services rendered.

If your doctor is not a participating provider with my insurance plan, **I understand that I bear sole financial responsibility for the payment of my account.**

If I do not have any insurance coverage, I agree to be responsible for the full balance.

Payment is expected in full at the time services are rendered. Payment of one half is expected before eyeglasses or contacts will be ordered. Eyeglasses and contact lenses must be paid in full at the time of dispensing.

Signature of patient or guardian _____ **Date signed** _____

Patient Name _____ Insured Name _____

Medical Insurance: Primary Coverage _____ Secondary Coverage _____

Vision Insurance/Plan: Primary Coverage _____ Secondary Coverage _____

Medical Insurance: *If your visit is for a medical eye problem, such as pink eye, cataracts, diabetic testing, or other non-vision issues, or if during your routine vision exam, a medical eye issue is found, depending on your plan, you may be covered by your medical insurance. Be aware that we may need a referral or you may have to return to our office for a follow-up visit.*
Vision Plan: *Covers routine eye exam, refraction, eye health screening -- including diabetic screening -- and prescription for glasses/contacts; some include materials such as glasses and contacts.*

MEDICARE PAYMENT & MEDICAL RECORDS RELEASE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Biermann Eye Health for any services furnished to me by this provider. I authorize the release of medical and financial information to the Health Care Financing Administration and its agents to determine benefits payable for services from this provider. I request payment of authorized secondary insurance benefits to be made to this provider and also authorize the release of medical information to the secondary insurer to determine benefits payable for services from the provider.

Patient signature _____ **Date signed** _____

Patient Name _____ Medicare # _____

Name of secondary insurance _____ Policy # _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Biermann Eye Health Notice of Privacy Practices (HIPAA).

Date _____

Patient Name _____ **Signature** _____