

FINANCIAL POLICY

- * The patient is responsible for all fees. Full payment is due at the time of service unless other arrangements have been made in advance.
- * We will accept assignment on your insurance benefits and will expedite insurance claim processing to insure prompt and accurate reimbursement.
- * Deductible and co-payments are due at time of service on participating insurance programs.
- * If insurance payment is not received within 60 days of your date of service, the patient becomes responsible for payment of the outstanding balance.
- * Late charges of 2% will be assessed against the outstanding balance for any amount owed over 60 days. This charge will be assessed monthly until the account is paid in full.
- * Delinquent unpaid balances including previous adjustments will be forwarded to a collection agency or attorney.

I have read and understand this financial policy and agree to its terms. I agree to pay for services rendered. I agree to pay the attorney fee and collection costs in the event it becomes necessary to retain such services for collection of my account.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT

I authorize the release of medical information and records concerning treatment to Medicare, Medigap and/or other insurance companies and assign my claim for Medical Benefits to the extent permitted under applicable law or insurance agreements. I release all legal responsibility or liability that may arise from the above authorizations and agreements.

Patient Signature: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____

**OCULAR AND GENERAL MEDICAL HISTORY AND
REVIEW OF GENERAL MEDICAL HISTORY**

Patient Name: _____ Date: _____

OCULAR HISTORY

What is the main problem you are having with your eye(s)? _____

List previous eye problems and surgeries/date: _____

List all eye medications: _____

Please check any of the symptoms that bother you significantly:
Circle **R** (right eye) and/or **L** (Left eye)

_____ "Lazy Eye" since birth	R	L	_____ Severe eye injury	R	L
_____ Eye glasses worn at age	_____	_____	_____ Bulging forward	R	L
_____ Droopy lid	R	L	_____ Double vision	R	L
_____ Burning	R	L	_____ Tearing eye	R	L
_____ Loss of side vision	R	L	_____ Eye redness	R	L
_____ Eye discharge	R	L	_____ Eye pain/ache	R	L
_____ Floating spot	R	L	_____ Cobwebs in vision	R	L
_____ Glare or halos	R	L	_____ Foggy vision	R	L
_____ Blind spot in vision	R	L	_____ Cloudy vision	R	L
_____ Lids matted together in morning	R	L	_____ Excessive light sensitivity	R	L
_____ Straight lines look crooked/wavy	R	L	_____ Feels like something is in the eye (sand/lashes, etc.)	R	L

LIST MEDICAL PROBLEMS, MEDICATION AND DOSAGE

PROBLEMS

MEDICATION/DOSAGE

_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES TO MEDICATION

Ocular and General Medical History and Review of Systems Cont.

Circle any major or recent symptoms that you have had recently:

GENERAL:	Fever Loss of Appetite Weight Loss Fatigue Chills Night Sweats
SKIN:	Rash Change in Color Hair Increase/Decrease Nail Changes
LYMPH NODE:	Swollen Nodes or Tender Nodes
HEAD:	Trauma Headache Tenderness of Scalp Do you have Claustrophobia?
EAR:	Hearing Loss Ringing in Ears Recent Infection
NOSE:	Loss of Smell Itching/Allergy Sinus Problem/Pain Frequent/Recent Nosebleeds
THROAT:	Jaw Cramping or Pain with Eating or Talking Mouth Ulcer/Sore Tooth Infection (recent) Difficulty Swallowing
NECK:	Stiffness Pain Nodule/Bump
CHEST:	Cough (producing mucous?) Pain Shortness of Breath Unable to Breathe While Lying Down Bloody Sputum Exposure to TB
HEART/VESSELS:	Angina Faintness Poor Circulation Abnormal Rhythm Murmur High Cholesterol Blood Disorder

Ocular and General Medical History and Review of Systems cont.

- GASTRO-INTESTINAL: Abdominal Pain
 Diarrhea
 Nausea/Vomiting
 Fullness or Mass
 Bloody Stools
 Jaundice

- GENITO-URINARY: Sore or Ulcer
 Discharge
 Pain on Urination
 Difficulty with Flow of Urine
 Sexually Transmitted Disease
 Kidney Disease/Failure

- EXTREMITIES: Joint Pain/Swelling
 Lower Back Stiffness in Morning
 Arthritis (Type _____)
 Osteoporosis (Brittle Bones)
 Shoulder or Hip Muscle Ache

- NEURO: Loss of Consciousness
 Seizures
 Memory Loss
 Stroke
 Loss of Ability to Feel/Move Part of Body
 Can You Lie Flat on Your back Comfortable?

- ENDOCRINE: Inappropriate Milk from Breast
 Increasing Hand/Hat Size
 Increased Thirst, Urination and Weight Loss
 Change in Pigmentation of Skin
 Thyroid Problem

FAMILY HISTORY

Any Eye Disease or Blindness in Relatives? _____

PARENTS

MOTHER: Alive / Deceased Age: _____
 Medical Problems: _____

FATHER: Alive / Deceased Age: _____
 Medical Problems: _____

BROTHER/SISTER: Medical Problems: _____

Ocular and General Medical History and Review of Systems cont.

SOCIAL HISTORY

Occupation(s): _____

Do you drive? _____ Overseas Travel: _____

Animal Exposure/Pets? _____

Tobacco Use: _____ Alcohol Use: _____

Past Residences: _____

Recreational Drug Use: _____ Do you eat undercooked Meat: _____

If you are Retired, what was your Occupation: _____

Please list the Name and Address of your Medical Physician:

I have completed this Medical History to the best of my ability.

Signature: _____ Date: _____

Thank you.