Visionary Eye Care Health History Form

May fax completed form to (870) 972-5684 or scan and send as an attachment to woodhoffman@hotmail.com

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

Social Security #: ____ - ___ - ____ Phone #: (H) _______________ (C) _______________(W) ___________

Address: ____ City, State & Zip: ________________________

Email: ____ Primary Care Physician/Clinic: _____________

Emergency Contact & Phone #: ____

Employer/School of Patient: ____Occupation: ________________

Marital Status: __________ Spouse/Parent (Responsible for bill): _____________________________________

CURRENT Visual Symptoms: Please circle all that apply.

REVIEW OF SYMPTOMS – PERSONAL MEDICAL HISTORY

List any prescription or OTC eye drops / ointments used regularly: ____

List the nature and date of any significant eye injuries: ____

List any eye surgeries you have had and the approx. dates: _________________________
Surgeon? ________________

Do you have: Glaucoma? ______ Cataracts? ________ Macular Degeneration? ________
Retinal Problems? _______

Medications and / or drugs (including herbal) that you are taking.

Attach a detailed list if more than 6 medications. Returning patients may also receive a printout of previous medications to compare on your exam date.

1._____________________________________
4._____________________________________
2._____________________________________
5._____________________________________
3._____________________________________
6._____________________________________

YOUR FAMILY HISTORY - Has anyone in your family living or deceased been diagonosed with:

Codes: GP-grandparent, F-father, M-mother, S-sister, B-brother, CH-child, A-aunt, U-uncle
Returning patients may update changes since last eye exam.

Yes / No Blindness __________ Yes / No Cancer __________

Yes / No Cataract __________ Yes / No Diabetes __________

Yes / No Glaucoma __________ Yes / No Heart Disease __________

Yes / No Macular Degeneration __________ Yes / No High Blood Pressure __________

Yes / No Retinal Detachment __________ Yes / No Kidney Disease __________

Yes / No Crossed Eyes __________ Yes / No Lupus __________

Yes / No Arthritis __________ Yes / No Thyroid Disease __________

SOCIAL HISTORY

Yes / No Do you wear eyeglasses? ________ All the time ______ For Office Work
________ Occasionally ______ Reading Only
________ Driving Only ______ Sunglasses Protection

Yes / No Do you wear contact lenses? ________ Soft ______ Gas Permeable
Brand: ______________________

Yes / No Alcohol Use _____ Occasional ______1 / day _____ 2 / 3 day _____ 4+ / day

Yes / No Tobacco Use _____ Occasional ____ 1 / 2 pack/day _____ 2+ pack / day ______ Chew

Patient Signature __________________________________ Dr. Signature ____________________________ ____/____/___
(Parent signature if under 18 years of age)

VISIONARY EYE CARE, P.A.

Courtney Hoffman, O.D. Matthew Hoffman, O.D. Douglas R. Wood, O.D.
2980 Browns Lane
Jonesboro AR 72401
(870) 972-5540
(870) 972-5684 Fax

BENEFICIARY AUTHORIZATION STATEMENT

____
Name of Beneficiary

____
Health Insurance Claim Number

I request that payment of authorized Medicare, Medicaid, Blue Cross / Blue Shield, and/or any other insurance benefits be made either to me or on my behalf to VISIONARY EYE CARE, P.A. for any services furnished me by these physicians/providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration, Medicaid, Blue Cross / Blue Shield, and its agents any information needed to determine these benefits or the benefits payable for related services.

____
Signature of Patient or Authorized Representative

____
Date

ACKNOWLEDGEMENT OF RECEIPT FOR HIPAA

I acknowledge that I received / offered a copy of ***Visionary Eye Car*e**
O.D. , Notice of Privary Practices.

Date: _______________

Patient Name: ____________________________ Signature:
____

~~~~~~

NAME: ___________________________ DATE OF
BIRTH:____________________

I would like for you to use the following ways to be contacted when my glasses / contacts are in, for appointment reminders, and for appointment confirmation: (please provide the appropriate contact number / address)

Phone call:

Primary # _________________________ Secondary
#__________________________

Text: Cell # _______________________________**(if texting is ok)**

Email:
~~~~~~

____
______

~~~~~~
~~~~~~~~~~~~~~~~~~~~~~

I give Visionary Eye Care, P.A. permission to leave a message, by name, on any phone number on record, to notifyof materials available for pick up.

Signature: ____ Date: ___________________