COMPREHENSIVE EYECARE OF CENTRAL OHIO

CompEyeCare.com
(614) 890-5692 • Fax (614) 890-5629
450 Alkyre Run Drive, Suite 100 • Westerville, OH 43082

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ DOB:_____
Date of last eye exam: _____ Physician: _____

SOCIAL HISTORY

Do you smoke ? YES ___ NO____ If yes, how much? _____How many years:_____
Do you drink alcohol ? YES ___ NO____ If yes, how much?_____

PERSONAL MEDICAL HISTORY

Please mark if these apply to you: ❍ **Check here if no significant personal medical history**

❍	Blindness	please describe _____
❍	Cataract	please describe _____
❍	Glaucoma	please describe _____
❍	Macular Degeneration	please describe _____
❍	Diabetes	please describe _____
❍	Hypertension	please describe _____
❍	Heart Disease	please describe _____
❍	Stroke	please describe _____
❍	Cancer	please describe _____
❍	Thyroid Disease	please describe _____
❍	Arthritis	please describe _____
❍	Depression	please describe _____
❍	Respiratory	please describe _____
	Other: _____	please describe _____

FAMILY HISTORY *(Parent, Grandparent, Sibling)*

Please mark if any member of your family have had hereditary diseases:

❍ **Check here if no significant family medical history**

❍	Cataract	relation _____
❍	Glaucoma	relation _____
❍	Macular Degeneration	relation _____
❍	Diabetes	relation _____
❍	Hypertension	relation _____
❍	Heart Disease	relation _____
❍	Stroke	relation _____
❍	Cancer	relation _____
❍	Thyroid Disease	relation _____
❍	Arthritis	relation _____
	Other: _____	relation _____

List ALL surgeries you have had (including ocular):

_____
_____
_____

ANY KNOWN DRUG ALLERGIES	REACTION

MEDICATION	DATE STARTED	FREQUENCY	STRENGTH

EYE MEDICATIONS	EYE	DATE STARTED	FREQUENCY	STRENGTH
	R L			
	R L			
	R L			
	R L			
	R L			

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____

DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Social Security Number: _____

Occupation: _____

Employer: _____ Work Phone: _____

Spouse: _____ Spouse's Phone: _____

Family Physician: _____ Phone: _____

Pharmacy (Local) Address/Phone: _____

Pharmacy (Mail Order): _____

PRIMARY LANGUAGE

❍ English ❍ Spanish ❍ Somali ❍ American Sign Language ❍ Other: _____

RACE

❍ American Indian/Alaskan ❍ Native Hawaiian or Pacific Islander ❍ African American

❍ White ❍ Asian ❍ Decline to Specify ❍ Other: _____

ETHNICITY

❍ Hispanic or Latino ❍ Not Hispanic or Latino ❍ Decline to Specify

REASON FOR CONSULTING OUR PRACTICE

❍ Doctor Referral (Name):_____Dr. Address_____

❍ Family/Friend (Name):_____ ❍ ER/Urgent Care: _____

❍ Columbus Yellow Pages ❍ Delaware County Yellow Pages ❍ Insurance

PERSON RESPONSIBLE FOR BILL *(other than yourself)*

First Name: _____ Last Name: _____

Relationship: _____Phone:_____

Address: _____

City: _____ State: _____ Zip Code: _____

EMERGENCY CONTACT

First Name: _____ Last Name: _____

Relationship: _____Phone: _____

VISION COVERAGE

❍ VSP ❍ EYEMED ❍ Self-Pay

PRIMARY INSURANCE INFORMATION

Plan: _____

Policy Holder: _____ Relationship: _____

Policy Holder SS#:_____ Policy Holder DOB: _____

SECONDARY INSURANCE INFORMATION

Plan: _____

Policy Holder: _____Relationship:_____

Policy Holder SS#:_____ Policy Holder DOB: _____

FINANCIAL POLICY: By my signature below, I indicate that I understand that I am ultimately responsible for payment of my bill. Comprehensive EyeCare of Central Ohio (CECCO) will send my claim to the insurance company that I present at the time of the visit and will accept assignment on the plans that they are participating with. CECCO will send a claim, upon request, on my behalf, to insurances they are not participating with; I am however responsible for the full payment of the bill.

Co-pays and deductible are also due at the time of service.

ASSIGNMENT OF BENEFITS: I request that payment of authorized Medicare benefits and/or payment from my current insurance carrier/supplemental insurance be made on my behalf to CECCO for any service furnished to me. I further authorize the release of pertinent information needed to determine these benefits or the benefits payable for related services, to the Health Care Financing Administration and/or insurance carrier/supplemental insurance carrier as its agents.

NOTICE OF PRIVACY PRACTICES: I acknowledge I have been offered/received a Notice of Privacy Practices.

Sign: _____ Date: _____

Limited Patient Authorization for Disclosure of Protected Health Information **Form 7.31**

Please print all information. Form must be signed and dated each year.

Patient Name: _____

SSN: (last four digits): _____ **Date of Birth:** _____

Entity Requested to Release Information: Comprehensive EyeCare of Central Ohio_____

Purpose of request (who will be authorized to receive information) – I authorize the entity identified above to disclose or provide protected health information, about me to the individual listed below.

Who will be authorized to receive information (list the individual/entity who is to receive your PHI):

Individual/Entity Name: _____

Address: _____

Phone/Fax: _____/_____

Email *: _____

***Secure Communication** – Note that some fax and email transmission methods are not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not designate fax or email as your preferred method of disclosure if this is of concern to you.

Description of information to be disclosed – I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

☐ Office notes	☐ nursing home, home health, hospice, and other physician records
☐ Lab results, pathology reports	☐ record of HIV and communicable disease testing
☐ x-rays	☐ record of mental health or substance abuse treatment
☐ financial history report (previous 3 years only)	☐ Only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year of your last signature below unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

_____

Patient or authorized representative signature date

_____

Patient or authorized representative signature date

You have the right to receive a copy of signed authorizations upon request.