

Medical History Record

For your convenience, please complete the following form prior to arriving at our office.

Patient Name _____

Date of Last Eye Exam _____ Name of Previous Eye Doctor _____

Date of Last Medical Exam _____ Name of general physician _____

**PERSONAL MEDICAL INFORMATION: Do you have problems with any of these systems?
If YES, please check box.**

- | | | |
|---|---|---|
| <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Nervous System | <input type="checkbox"/> Mental |
| <input type="checkbox"/> Ear/Nose/Throat | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Endocrine (Glands) |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Blood/Lymph |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Skin | <input type="checkbox"/> Allergic/Immunologic |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Surgeries (what type & when) _____ | |

Are you in good health? Yes No

Any allergic reactions to medications or other substances? Yes No
If yes, please list _____

Please check Yes or No

Do you smoke? Yes No How much? _____
Do you drink alcohol? Yes No How Much? _____
Do you take medicare? Yes No Please list names & how often _____

Do you use other substances? Yes No

Do you have family history of any of the following? If Yes, please check box.

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Retinal Detachment	<input type="checkbox"/> Cataracts

Please explain any boxes you have checked _____

Do you have any of the following? If Yes, please check box.

<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Eye Injuries	<input type="checkbox"/> Wear Glasses
<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Eye Surgeries	<input type="checkbox"/> Wear Contacts

Any eye problems at this time? Please explain _____

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature _____ Date _____

_____ Reviewing Doctor's Initials

PATIENT INFORMATION

Last Name _____
First _____ MI _____
Address _____
Apt. # _____ City _____
State _____ Zip _____
Home Phone _____
Work Phone _____
Cell Phone _____
E-Mail Address _____
Occupation _____
Employer _____
Social Security # _____
Birth Date _____ Age _____
 Male Female
 Single Married Divorced Widowed
Referred By _____
Spouse's Name _____
If child, parent's names _____
Emergency Contact _____

Phone _____

RESPONSIBLE PARTY

Same as above

Last Name _____
First _____ MI _____
Address _____
Apt. # _____ City _____
State _____ Zip _____
Home Phone _____
Work Phone _____
Cell Phone _____
Occupation _____
Employer _____
Social Security # _____
Birth Date _____ Age _____
 Male Female
 Single Married Divorced Widowed
Relationship to Patient _____

All charges are expected to be paid at the time of service unless arrangements have been cleared with the office manager. \$20.00 charged on all return checks. Amounts over 30 days will be charged interest at 1½% per month with a minimum charge of \$.50 per month. Should collections become necessary, the responsible party agrees to pay an additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs.

INSURANCE INFORMATION

(We will be happy to copy your insurance cards)

VISION INSURANCE CARRIER

Address _____
City _____
Phone _____
Insured's Name _____
I.D. Number _____
Group Number _____
Plan / Program Name _____

MAJOR MEDICAL INSURANCE CARRIER

Address _____
City _____
Phone _____
Insured's Name _____
I.D. Number _____
Group Number _____
Plan / Program Name _____

SECONDARY INSURANCE CARRIER

Address _____
City _____
Phone _____
Insured's Name _____
I.D. Number _____
Group Number _____
Plan / Program Name _____

I request that payment of insurance benefits be made on my behalf to Dr. William J. Bogus. I authorize any holder of medical information about me to release any information needed to determine those benefits or the benefits payable for related services. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of services rendered on my behalf and of my dependents.

Signature _____

Date _____