

COCKRELL EYECARE CENTER MEDICAL HISTORY QUESTIONNAIRE

TODAY'S DATE: ____/____/____ LAST EYE EXAM: ____/____/____

PATIENT NAME		SOC SEC. #	BIRTHDATE	INSURANCE MEDICAL GROUP & NO.	
ADDRESS			CITY	STATE	ZIP
HOME PHONE (OR PARENT IF MINOR)	BUSINESS PHONE		OCCUPATION	EMPLOYER	
NAME OF PARENT OR SPOUSE (please circle)		GRADE IF STUDENT	DO YOU USE A COMPUTER SCREEN? <input type="checkbox"/> NO <input type="checkbox"/> YES; HOW MUCH		
METHOD OF PAYMENT <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHECK <input type="checkbox"/> CASH <input type="checkbox"/> CREDIT CARD		GUARANTOR		HAVE WE SEEN OTHER MEMBERS OF YOUR FAMILY? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, WHOM	
MEDICAL DOCTOR'S NAME	DR.'S PHONE	REFERRED BY		DATE OF LAST MEDICAL EXAM	

Medical History

Do you have any allergies to medications? no yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies).

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, or eye injury: _____

Are you pregnant and/or nursing? no yes
 Do you wear glasses? no yes If yes, how old is your current pair of lenses? _____
 Do you wear contact lenses? no yes If yes, how old is your current pair of lenses? _____
 Type of contact lenses: rigid soft extended wear Other Are they comfortable? no yes

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE / CONDITIDION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment / Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Medical History *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check Box)

Do you drive? no yes If yes, do you have visual difficulty when driving? no yes If yes, describe:

Do you use tobacco products? no yes If yes, type/amount/how long? _____
 Do you drink alcohol? no yes If yes, type/amount/how long? _____
 Do you use illegal drugs? no yes If yes, type/amount/how long? _____
 Have you ever been exposed to or infected with? no Gonorrhea Hepatitis HIV Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?		NO	YES	?
CONSTITUTIONAL				EAR, NOSE, MOUTH, THROAT			
Fever, Weight Loss / Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies / Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY				Sinus Congestion			
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL				Post-Nasal Drip			
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat / Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES				Asthma			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision / Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR / CARDIOVASCULAR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals / Kidney / Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing / Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BONES / JOINTS / MUSCLES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare / Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC / HEMATOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes / Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE				ALLERGIC / IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid / Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

Doctor's Signature _____

Date _____

Receipt of Notice of Privacy Policies & Consent Form

Cockrell Eyecare Center and The Laser Eyecare Center of Stillwater

Patient Name: _____

Patient Number: _____ Patient Phone Number: _____

Patient Address: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The **Notice of Privacy Practices** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our **Notice of Privacy Practices**, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our **Notice of Privacy Practices**. Our **Notice of Privacy Practices** will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our websites: www.cockrelleyecare.com or www.stillwaterlasik.com.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our **Notice of Privacy Practices**.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our **Notice of Privacy Practices**, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our **Notice of Privacy Practices** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Cockrell Eyecare Center or The Laser Eyecare Center of Stillwater.

Signature Date

Persons authorized to receive personal information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient Print Name

Source of Authority: _____

Office Policy

WE ARE IN NETWORK WITH THE FOLLOWING INSURANCE COMPANIES:

INSURANCE/COMPANY NAME

BENEFIT

ARMSTRONG/BCBS

ROUTINE EYE EXAM/MEDICAL VISITS

BLUE CROSS BLUE SHIELD

ROUTINE* AND MEDICAL VISITS

COAST TO COAST-DISCOUNT PLAN

ROUTINE VISION ONLY

COMMUNITY CARE

ANNUAL VISION EXAM ONLY W/ PRE-

AUTHORIZATION-NO MEDICAL

COVENTRY/MAIL HANDLERS

ROUTINE* AND MEDICAL VISITS

CREC/PPO-OK

ANNUAL ROUTINE VISION/MEDICAL VISITS

HEALTHCHOICE

MEDICAL VISITS ONLY

MEDICAID/SONERCARE

ROUTINE AND MEDICAL VISITS

MEDICARE

MEDICAL ONLY

PPO OKLAHOMA/CCN/1St Health

ROUTINE* AND MEDICAL VISITS

PREFERRED COMMUNITY CHOICE

ROUTINE* AND MEDICAL VISITS

SMC/OK HEALTH NETWORK

ROUTINE EXAM ONLY/MEDICAL VISITS

TRICARE

ROUTINE VISION AND MEDICAL VISITS

VSP-VISION SERVICE PLAN

ROUTINE VISION W/ PRE- AUTHORIZATION

****ROUTINE VISION BENEFITS NOT ON ALL PLANS-WE WILL VERIFY IF ANY BENEFITS ARE AVAILABLE WITH YOUR GROUP.***

WE WILL FILE ANY MEDICAL CLAIM FOR YOU IF YOUR PLAN ALLOWS US TO PROVIDE YOU WITH A MEDICAL SERVICE. (SOME PPO'S AND HMO'S WILL NOT COVER YOU IF YOU ARE OUT OF NETWORK-IT'S YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE AND YOUR NETWORK)

If you have insurance for vision care **or** for medical care, we need to know the name of your insurance company as well as any additional information necessary to file a claim. Many companies now require pre-approval or pre-authorization before eye care services are performed. ***If your insurance requires pre-authorization and it is not requested prior to your eye care, the insurance company will not pay the bill and you will be responsible for the fees.***

1. Patients who carry Health Care Insurance should remember that professional services are rendered and charged to the patient and not to the Insurance Company.
2. Even though we will file your insurance claim, this office cannot accept responsibility for negotiating a settlement on a disputed claim. **You are ultimately responsible for the balance on your account should your insurance company deny your claim for any reason.**

ASSIGNMENT OF BENEFITS AUTHORIZATION

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the above information on this sheet and have provided the information requested if applicable on my insurance. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health insurance or routine vision coverage. I request that payment of authorized medical or routine vision benefits be made to Cockrell EyeCare Center, Inc. on my behalf for any services furnished by Cockrell EyeCare Center, Inc. if applicable. I authorize Cockrell EyeCare Center, Inc. to release to the health plan indicated if applicable, any information needed to determine these benefits or benefits payable to related services.

Date _____ Signature _____