RETURNING PATIENT HISTORY REVIEW

First Name: ________________________ Last Name: ____ Middle Initial: ______ Preferred Name: _______________

Home Address (if changed): ____Zip: ___________City: ____________________ State: ___

Which phone number would you prefer we use to contact you? **Home** **Work** **Cell :** ____________________________________

Marital Status: **Single** **Married** **Other**

***Insurance Changes*:**

Primary Medical Insurance: ____ Secondary Medical Insurance: ____________________________________

Vision Insurance: ____ Insured Social Security Number: __________________________________

Insured's Birth Date:____ Insured's Employer: ____

NOTICE OF PRIVACY PRACTICES: I/We have been offered a copy of Complete Eye Care of Medina's statement on privacy practices
AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Complete Eye Care of Medina LLC to release any medical or incidental information that may be necessary for medical benefit of in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.
CONSENT FOR TREATMENT: I/We hereby authorize Complete Eye Care of Medina LLC to administer diagnostic and medical procedures as may be necessary for proper health care.
OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider. I understand that any remaining balance on my account after 30 days will accrue interest at an annual rate of 18% and that I will be responsible for any reasonable costs associated with the collection of past due balances.
VISION PLAN COVERAGE: I/We understand that only one vision plan may be used for exam/materials per visit-per patient and that the vision plan to be used must be chosen before the exam occurs and can not change at a later date

SIGNATURE: ____ DATE: ____

CHIEF COMPLAINT

How can we help you today? In this space please check/explain any signs and/or symptoms you are experiencing. Medical insurance will only cover if there is a medical reason for the exam/test such as loss of vision, headaches, eye pain, eye itching or burning, redness, glaucoma, cataracts, floaters, dry eyes, etc.

Loss of vision	**Floaters**	**Eye pain/soreness**	**Glare**	**Dry eyes**
Blurred vision	**Crossed eyes**	**Watery eyes**	**Light sensitivity**	**Red eyes**
Double vision	**Flashes of light**	**Sandy/gritty feeling**	**Tired eyes**	**Burning/itching**

Other (explain):

HISTORY OF PRESENT ILLNESS

Location *Which eye has the problem?* **Right** **Left** **Both**
Quality *How is it effecting you?* **Bothersome** **Aware** **Painful**
Severity *How severe is the problem?* **Mild** **Moderate** **Severe**
Duration *How long have you had the problem?* ________________________

Timing *Is it new, ongoing, returning?* **New** **Ongoing** **Returning**
Context *Associated w/:* **Infection** **Medical condition** **Injury** **Surgery**
Modifiers *Previous treatment?* **Drops** **Medication** **Other:** __________
Symptoms *Are there associated symptoms?* **Headache** **Other:** __________

Do you sometimes experience dry eyes? **Y N**
Do you work at a computer ? **Y N**
Prefer not to wear your glasses at times? **Y N**
Want information on thinner / lighter lenses? **Y N**
Like a non-surgical option to correction? **Y N**

Are your eyes sensitive to sunlight? **Y N**
Problems with reflections and/or glare? **Y N**
Interested in newer contact lens technology? **Y N**
Like information on LASIK vision surgery? **Y N**
Participate in sporting activities / hobbies?
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