

Patient Health and History Form

Last Name _____ First Name _____

Address _____ City _____ Zip Code _____

Hm Phone _____ Wk Phone _____ E-mail _____

Employer _____ Occupation _____ Extensive computer work? Yes / No

Address _____ City _____ Zip Code _____

Date of Birth _____ Past Ocular injuries/surgery _____ Spouse _____

Physician _____ Previous Eye Doctor _____ Last Exam _____

List any health problems high blood pressure___ diabetes___ other _____

List any medication you take _____

Known drug allergies / none _____ Family history: glaucoma diabetes other _____

What is your major vision complaint _____

This visit is for General exam ___ Glasses ___ Contact lenses ___ Lasik surgery ___ Eye problem ___

Do these conditions apply to you: Headaches___ Eye pain___ Light Flashes___ Loss of Vision___ Floaters___

Current visual appliances: Contacts: soft___ hard___ Glasses: Single Vision___ Multifocals___ Progressive___

Many eye care insurances, such as MPMG and VSP, cover the Standard Visual Exam. Contact Lens services are a separate procedure and a separate fee will be charged. Check with the receptionist to determine the fees for determining and writing your contact lens Rx.

Financially responsible party: Self___ VSP___ Mills/Pen Med Grp___ Other _____

This office will try to assist you with your vision insurance and help you to benefit the most from your coverage but you are ultimately responsible for any fees and charges incurred in this office. If your insurance carrier refuses to pay for services or materials, you will be billed for any balance due. You are responsible for all unpaid balances, collection fees, 10% annual interest and all attorney fees if we need to send your account to collections. We will be happy to give you information on your insurance billing but any questions regarding insurance payment should be directed to your insurance carrier.

How did you hear about us: Insurance referral ___ Burl/Hills phone book ___ Friend/Relative___

...who was nice enough to refer you to this office _____

Federal law mandates that we enforce privacy laws to protect your identity. Please read our Notice of Privacy Practices and Voluntary Consent form. We will only use your health information for the purposes of treatment, payment and health care operations. By my signature, I understand these notices and I consent to allow the office of Leonard Ma, OD to use and disclose my health information for treatment, payment and health care operations.

Signature _____ Date _____