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 ______________________________