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established 1953

# Medical Questionnaire

TODAY'S DATE: _____

Patient's Name: _____ Date of Birth: ____/____/____

Parent Name (if child): _____ Occupation: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Insured Name: _____ Insured's Date of Birth: ____/____/____

Insured Social Security number: _____

Patient Relationship to Insured (circle one): Self Spouse Child Other

| Primary Insurance Company | Secondary Insurance Company |
|---|---|
| Company: _____ | Company: _____ |
| Policy #: _____ | Policy #: _____ |
| Group #: _____ | Group#: _____ |

Medicare patients, is Medicare your primary insurance carrier? (circle one) Yes No

Primary Care Physician: _____ Last Physical: _____

Do you have or had problems with the following; **if yes, please specify**:

1. Weight loss/gain? ☐ Yes ☐ No _____
2. Ears, Nose, Mouth, Throat, Sinus? ☐ Yes ☐ No _____
3. Cardiovascular? (TIA, Stroke, Circulation) ☐ Yes ☐ No _____
4. Respiratory? ☐ Yes ☐ No _____
5. Gastrointestinal? ☐ Yes ☐ No _____
6. Genitourinary? ☐ Yes ☐ No _____
7. Musculoskeletal? (Arthritis, muscle/joint pain... ) ☐ Yes ☐ No _____
8. Skin and or breast? ☐ Yes ☐ No _____
9. Neurological? ☐ Yes ☐ No _____
10. Psychiatric? ☐ Yes ☐ No _____

**PLEASE TURN THIS FORM OVER AND COMPLETE THE BACK**

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11. Endocrine? (Diabetes, thyroid, hormone,...) ☐Yes ☐ No _____

12. Hematological (blood)/ lymphatic? ☐ Yes ☐No _____

13. Allergic/immunologic? ☐ Yes ☐ No _____

14. Eyes? ☐ Yes ☐ No _____
(ARMD, Glaucoma, Diabetic retinopathy, LASIX, Sensitivity to lights, Dry eye, Blurred/Decreased Vision, Trouble reading, difficulty driving or seeing the blackboard, Trouble with night vision,...)

Please list any medications/pills you take: (include vitamins, aspirin, herbal supplements) _____

_____

Please list any allergies to medications: _____

Please list any major surgeries, injuries or serious illnesses: _____

Do/ Did you use tobacco? ☐ Yes ☐ No If yes, how many per day? _____

Do/ Did you use alcohol? ☐ Yes ☐ No If yes, how many glasses per day? _____

Do you drive? ☐ Yes ☐ No If yes, do you experience problems with night driving? _____

Please list any avocations or hobbies: _____

How long ago was your last eye exam? _____ How old are your glasses? _____

Do you wear contact lenses? ☐ Yes ☐ No If no, are you interested in being fit with contact lenses today? ☐ Yes ☐ No
If yes, are they soft contact lenses? ☐Or hard contact lenses? ☐ Are the disposable contact lenses? ☐Yes ☐ No
How old is the pair of contact lenses you are wearing today?
What cleaning solutions do you use?
Are you interested in LASIK surgery or learning more about this procedure? ☐ Yes ☐ No

FAMILY HISTORY

Is there family history of; **<u>if yes, please specify</u>**:

1. Cardiovascular disease? ☐Yes ☐ No _____

2. Respiratory problems? (Asthma, emphysema, COPD,...) ☐ Yes ☐ No _____

3. Cancer? ☐ Yes ☐ No _____

4. Endocrine problems? (Diabetes, Thyroid,...) ☐Yes ☐ No _____

5. Eye problems? ☐ Yes ☐ No _____

6. Other? _____

How did you learn about our office? ☐ My insurance company ☐ Yellow Pages ☐ Advertisement

☐ Driving by ☐ Referral—if so, who: _____

Do you participate in a medical savings plan/cafeteria plan? ☐ Yes ☐ No

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1660 Western Ave, Albany, NY 12203
518-218-7970 (Phone)
518-218-7919 (Fax)

I understand that Casey Vision Care will be billing my insurance company. If, for any reason, my insurance company does not pay Casey Vision Care for services provided, I agree to pay Casey Vision Care in full for all services rendered.

Signature: _____ Date: _____

# Notice of Privacy Practices

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1660 Western Ave, Albany, NY 12203
518-218-7970 (Phone)
518-218-7919 (Fax)

We are required by law to maintain the privacy of your health information and to provide you notice of our legal duties and privacy practices with respect to your health information.

The following are some examples as to the way we use and disclose health information:

- For treatment
- For payment
- For health care operations
- Appointment Reminders
- Treatment recommendations/ alternatives and/or services/benefits
- Individuals involved in your care (or payment of your care)
  - See hand out for more detailed explanation

We will use and disclose your health information as required by federal, state and local law without your authorization.

Right to complain: If you have questions about this notice or would like to file a complaint about our privacy practices, please direct inquires to The U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, S.W. , Washington, DC 20202, or call toll free 877-696-6775.

**By signing below you acknowledge that you have reviewed a copy of the privacy practices of Casey Vision Care.**

By signing this form, I acknowledge that I reviewed a copy of Casey Vision Care's Notice of Privacy Practices.
I further consent to the release of my health information for the purposes of treatment, payment, and health care operations and as authorized or required by law under the circumstances described above and in the Notice of Privacy Practices.
I have supplied the current and correct insurance information and will notify the office immediately of any changes in coverage. Your insurance is a contract between you and the insurance company.

Patient Name: _____

Signature: _____ Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient: _____

Print Name: _____

Source of Authority: _____