

Park Lane Eye Care Questionnaire

Today's Date: _____

Patient

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____

Social Security: (Last 4 digits only) _____

Single Married Separated Divorced Widowed

How did you hear about us? _____

Birth Date: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Employer: _____

Occupation: _____

Insured Person

Name: _____ Birth Date: _____ Relation to Patient: _____

Address: _____

Employer: _____ Occupation: _____

Patient Medical History

Last Eye Exam _____

Name of Medical Doctor: _____ Last Medical Exam _____

Do you have any allergies to Medications? _____ If yes, explain. _____

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

List all major injuries, surgeries and /or hospitalizations you have had. _____

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

Are you pregnant and / or nursing? Yes No

Do you wear glasses? Yes No If yes, how old is your present pair of glasses? _____

Do you wear contact lenses? Yes No If yes, how old is your present pair of lenses? _____

Type of contact lenses? Rigid Soft Sleeping / Extended Wear Other _____

Please note any Family History (parents, grandparents, siblings, children, living or deceased) for the following conditions.

DISEASE / CONDITION	YES	NO	?	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"/>	_____

Please continue on reverse side.

Social 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? Yes No If yes, do you have visual difficulty when driving? Yes No If yes, explain.

Do you use tobacco products? Yes No If yes, kind / amount / how long?

Do you drink alcohol? Yes No If yes, kind / amount / how long?

Do you use illegal drugs? Yes No If yes, kind / amount / how long?

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Review of Systems. Do you currently, or have you ever had any problems in the following areas?

	YES	NO	?		YES	NO	?
Constitutional:				Ears, 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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:			
Eyes:				Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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:			
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:			
Sandy or gritty feeling	<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:			
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			
Light sensitivity Glare	<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"/>
Styes or Chalazions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic / Hematologic			
Flashers/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 and list medications.

Signature on File, Assignment of Benefits, Financial Agreement

Beneficiary Name (*print*) _____

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Dr. James Roberts for services furnished me by Dr. James Roberts. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Dr. James Roberts accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Dr. James Roberts, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Dr. James Roberts may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Dr. James Roberts for reimbursement for services rendered, and (2) any health care provider for continued patient care. Dr James Roberts may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that Dr James Roberts maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Dr James Roberts has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Dr James Roberts if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES:** I understand that Dr James Roberts's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Dr James Roberts to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Dr James Roberts, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Dr James Roberts for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Dr James Roberts. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Dr James Roberts. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Beneficiary Signature or Authorized Party

Date

ACKNOWLEDGMENT OF RECEIPT

**I acknowledge that I have read and or received a copy of James Roberts, O.D.
Notice of Privacy Practices.**

Patient Name _____

Relationship to Patient _____

Print Name _____

Signature _____ Date _____