

PATIENT HISTORY QUESTIONNAIRE

Date: _____

Thank you for choosing our office. In order to serve you properly, we need the following information. All information will be confidential.

Dr. Miss Last Name _____ First Name _____ MI _____

Mr. Ms. Address _____ City _____ State _____ Zip _____

Mrs. Other Home phone _____ Work phone _____ cell phone _____

Email address _____ S.S. # _____ - _____ - _____ Birthdate _____ Gender M/F _____

Patient or parent/Guardian's employer _____ Patient's occupation _____

Emergency contact _____ Phone _____ Relationship to patient _____

Spouse or parent/guardian's name _____ Employer _____ phone _____

Patient: Full-time Student? Yes No

How would you like us to contact you? _____

Whom may we thank for referring you? _____

Ethnicity: _____

RESPONSIBLE PARTY

Name of person responsible for this account _____

Relationship to patient _____

Address _____ Home Phone _____ Cell Phone _____

Birthdate _____ Employer _____ Work Phone _____

INSURANCE INFORMATION

Routine Well Vision Insurance
Name of insured _____

Medical Insurance
Name of insured _____

Relation to patient _____ Birthdate _____

Relation to patient _____ Birthdate _____

Insured SS# _____ Group# _____

Insured SS# _____ Group# _____

Insurance _____

Insurance _____

Employer _____

Employer _____

AUTHORIZATION & RELEASE

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to the doctor. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I agree to be financially responsible for all charges relative to my provider plan.

If Harvey Eye Center is not a provider for my insurance, I understand that they will assist me in receiving reimbursement as much as possible, but I am responsible for my bill at the time of services. I have read and understand this information.

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN IF MINOR) Date _____

PATIENT HEALTH HISTORY

Patient Name _____

Last Eye Exam Date _____ With whom? _____ Primary Care Dr. _____

Eye Surgeries? Yes No Type _____ Date _____

Eye Injuries? Yes No Describe _____ Date _____

What brand of contact lenses do you wear? _____ Do you sleep with them in? _____

Smoker/Tobacco: Yes No Pregnant: Yes No

Have you or anyone in your family, been diagnosed with any of the following:

	Yourself		Family	
	Yes	No	Yes	No
Cataracts				
Glaucoma				
Maculaar Degeneration				
Lazy Eye (Amblyopia)				
High Blood Pressure				
Heart Attack				
Asthma/Emphysema				
Hepatitis				
Kidney Disease				
Arthritis				
Migraines				
Stroke				
Seizures				
Diabetes				
Thyroid Disease				
Shingles				
AIDS/HIV				
Cancer				
Other				

List of Current Medications:

List of Current Allergies:

Do you have any specific concerns about your eyes today?

HARVEY EYE CENTER

2148 N. Mall Dr.
Alexandria, LA 71303

318-442-0243

318-442-2406(Fax)

Toni C. Harvey, O.D.

PRIVACY NOTICE

Harvey Eye Center requires your consent to collect personal information about you. Please read this consent for carefully and sign where indicated below.

This Medical Practice collects such information for the primary purpose of providing quality health care. We require you to provide us with your personal details and full medical history to allow us to properly assess, diagnose, treat and advise on all your health care needs.

I give my permission for my personal health information to be used for administrative purposes to assist in the running of Harvey Eye Center, including disclosure to others involved in my healthcare, such as treating doctors, and specialists within and outside this Medical Practice. This may occur through referral to other Doctors, or for medical test and in the reports or results returned to my doctor following referrals.

I understand by signing below that the Practice is authorized on my behalf to use my relevant personal health information, and I am free to withdraw my consent at any one time by verbal or written notification.

Print Name of Patient: _____ Date: _____

Signature of Patient: _____

Financial Agreement

I agree that in return for services provided to the patient by Harvey Eye Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Harvey Eye Center for payment. 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 Harvey Eye Center. **If co-payments and/ or deductibles are designated by my insurance company, health plan or ANY DISCRETIONARY fees NOT paid by my insurance.** I AGREE to pay them to Harvey Eye Center. However, it is understood that the undersigned and/or patient are primarily responsible for the payment of my bill.

Signature of Patient (Parent, if minor)

Date