AdvancedVisionCare
Dr. MICHAEL MATTHEWS

PATIENT HISTORY QUESTIONNAIRE

Today's Date_____

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name_____ First Name _____MI_____
Address_____ Emergency Contact Name_____
City, State, Zip_____ Phone (_____)_____
Cell Phone (_____) _____ Date of Last Eye Exam_____
Work Phone (_____) _____ Dilated? ☐ Yes ☐ No
Email Address _____ Referred By_____
Date of Birth_____ Primary Vision Coverage_____
Occupation_____ Social Security Number _____
Employer_____ Secondary Coverage_____

MEDICAL INFORMATION

How is your general health?_____
Do you take medications for any of these systems? (Please check Yes or No boxes.)

Gastrointestinal	☐Yes ☐No	Nervous	☐Yes ☐No	Endocrine	☐Yes ☐No
Ears/Nose Throat	☐Yes ☐No	Urinary	☐Yes ☐No	Blood/Lymph	☐Yes ☐No
Cardiovascular	☐Yes ☐No	Muscles/Bones	☐Yes ☐No	Allergic/Immunologic	☐Yes ☐No
Respiratory	☐Yes ☐No	Integumentary(skin)	☐Yes ☐No	Headaches	☐Yes ☐No
High blood pressure	☐Yes ☐No	Eyes	☐Yes ☐No	Mental	☐Yes ☐No

Please explain_____
Diabetes ☐ Yes ☐ No_____Type_____Date of diagnosis_____
Allergies to medication ☐ Yes ☐ No Which?_____Reactions?_____
Other health problems_____
Current medications_____
Have you had any operations? ☐ Yes ☐ No Kind?_____When?_____
Name of family doctor and/or primary care physician_____
Date of last visit?_____Date your blood pressure was last checked?_____

FAMILY HISTORY

High blood pressure	☐Yes ☐No	Relation_____	Macular degeneration	☐Yes ☐No	Relation_____
Diabetes	☐Yes ☐No	Relation_____	Retinal detachment	☐Yes ☐No	Relation_____
Glaucoma	☐Yes ☐No	Relation_____	Cataracts	☐Yes ☐No	Relation_____

PERSONAL EYE INFORMATION

Do you have any eye conditions or problems ☐ Yes ☐ No What Kind?_____
Have you had any eye operations? ☐ Yes ☐ No Type?_____Date_____
Have you had any eye injury? ☐ Yes ☐ No Kind?_____Date_____

Do you have glaucoma?	☐Yes ☐No	Cataracts?	☐Yes ☐No	Dry eyes?	☐Yes ☐No
Macular degeneration	☐Yes ☐No	Retinal detachment?	☐Yes ☐No	Blurred vision?	☐Yes ☐No
Do you wear glasses?	☐Yes ☐No	Contact Lenses?	☐Yes ☐No	Type_____	

Additional Information: _____

DOCTOR USE ONLY

Reviewed by_____ ☐ No changes Date_____
Reviewed by_____ ☐ No changes Date_____
Reviewed by_____ ☐ No changes Date_____

ADVANCED VISION CARE
Michael Matthews, O.D.
2926 Hillrise Drive
Las Cruces, NM 88011
575-522-6885

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This consent form allows us to use and disclose your health information for purposes of treatment, payment, and health care operations of this office.

We use information for treatment purposes, when, for example, we set up an appointment for you and call to remind you of scheduled appointments, when our doctor tests your eyes, when the doctor prescribes glasses or contact lenses, when the doctor prescribes medication, and when our staff helps you select and order glasses or contact lenses. We may disclose your health information outside of our office for treatment purposes if, for example, if we refer you to another doctor or clinic for eye care, if we send a prescription for glasses or contacts out to be filled, when we provide a prescription for medication to a pharmacist, or when we phone to let you know that your glasses or contact lenses are ready to be picked up.

We use your health information for payment purposes when, for example, our staff asks you about vision care plans that you may belong to, or about other sources of payment for our services, when we prepare bills to send to you or your vision care plan, when we process payment by credit card, and when we try to collect unpaid amounts due.

We may disclose your health information outside of our office for payment purposes when, for example, bills or claims for payment are mailed, faxed, or sent by computer to you or vision plan, or when we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.

It is completely your decision whether or not to sign this authorization form. **Please note that if you choose not to sign, we cannot release your information to your insurance company, thus we cannot bill them and will need to charge you for the full amount of this visit today.**

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization.

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name_____

Patient Address_____

Patient Phone Number_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient 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 (if other than parent) to sign this form:

Relationship to Patient _____ **Print Name** _____

Source of Authority _____