Patient History Form

Hi there! We know filling out paperwork for a medical visit can be a tedious task, so we try to make it a fun experience. After all, we're a friendly bunch, and we can't wait to get to know you better!

What is your full name (please print)? _____
Do you prefer to be called by a different name? If so, what's your preferred moniker? _____
How do you identify? ☐ Male ☐ Female ☐ Non-binary

Do you live around here? Please let us know where we can send you some snail mail!

_____
Street City State Zip

What about your electronic residence? Email: _____ (No worries, you won't be getting junk from us! We just use this for receipts, prescriptions, and appointment reminders)

Can we get your digits? Home: _____ Cell: _____ Can we text you? ☐ Yes ☐ No

How would you prefer we keep in touch?
☐ Home phone ☐ Cell phone ☐ Snail mail ☐ Email ☐ Text message ☐ Carrier pigeon

Also, we hope it's not too personal of a question, but what's your birthday? _____
...and your race/ethnicity? _____ Thanks!

So what do you do for a living? _____ Who is your employer? _____ Awesome!
Another personal question, what's your marital status? (We're ummm...asking for a friend!) _____

How many hours of computer work for you each day? Be sure to include smart phones/tablets…they're computers and have feelings too! _____ Do your eyes get tired, heavy, or irritated with computer work? ☐ Yes ☐ No

What do you like to do for fun? ☐ Biking ☐ Golfing ☐ Sewing ☐ Reading ☐ Swimming ☐ Tablet time
☐ Sitting ☐ Running ☐ Shooting ☐ Gaming ☐ Skiing ☐ Napping ☐ Watching movies ☐ Yard work
☐ Musical instruments ☐ Home renovation ☐ Fight Club ☐ Playing with pets ☐ Hiking ☐ Boating/Fishing

Who can we thank for introducing us? _____

BORING STUFF ALERT!!
Do you have **medical insurance**? ☐ Yes ☐ No If yes, please provide your insurance card and official identification (like your driver's license) so we can keep a copy of it on file, just in case.

Do you have **vision insurance**? ☐ Yes ☐ No Do they provide a card? ☐ Yes ☐ No ☐ Not sure

No problem if not, we may just need a little information to find your benefit. Do you know the name of the insurance company? ☐ Yes ☐ No If so, which company is it? _____. If not, we just need the name of the primary member on the account, that person's birthday, and the last four digits of their social security number:

_____
Primary member Date of birth Last four of SS#

Speaking of insurance…gotta love the weird questions. They call it "demographic data," we call it "social history..."
Are you a smoker? If so, how much/how often? ☐ No ☐ Yes: _____
Any recreational drug use? If so, what kind? ☐ No ☐ Yes: _____
Do you drink alcohol? If so, how much/how often? ☐ No ☐ Yes: _____

Patient History Form

Let's get down to business! First off, when and where was your last eye exam? _____

What actually brings you in to see us today? What symptoms have you been experiencing?
☐ Visual disturbance (distance blur, near blur, both distance and near blur, seeing wavy patterns, black spots or lines, rings or halos around lights, etc.) ☐ Eye irritation or pain ☐ Redness ☐ Itching ☐ Burning sensation
☐ Light sensitivity ☐ Discharge (either watery or goopy) ☐ Double vision ☐ Dryness ☐ Headaches
☐ Pressure feeling around/behind eyes ☐ Flashes of light ☐ Sandy/gritty feeling ☐ Difficulty seeing at night
☐ Other (please specify): _____

Do you have any eye-related disease? ☐ Glaucoma ☐ Cataracts ☐ Macular degeneration ☐ Other: _____

As it turns out, your eyes are attached to your body, and everything is connected! So, how's your health in general?
Do you have (or have you previously had) any conditions listed here? (Please select all that apply)

System/Constitutional		Endocrine		Gastrointestinal	
Fever	☐	Insulin dependent diabetes	☐	Crohn's	☐
Weight loss/gain	☐	Non-insulin dependent diabetes	☐	Colitis	☐
		Thyroid dysfunction	☐	Stomach ulcer	☐
Ear/Nose/Throat		Hormonal dysfunction	☐		
Sinus congestion	☐			Neurological	
Chronic cough	☐	Respiratory		Headaches	☐
Earache	☐	Asthma	☐	Migraines	☐
		Chronic bronchitis	☐	Seizures	☐
Cardiovascular		Emphysema	☐	Multiple sclerosis	☐
High blood pressure	☐	COPD	☐	Dizziness/Vertigo	☐
High cholesterol	☐				
Heart disease	☐	Lymphatic/Hematological		Immunological	
		Bleeding problems	☐	Lupus	☐
Integumentary		Bruising easily	☐	Rheumatoid arthritis	☐
Eczema	☐	Anemia	☐	HIV	☐
Psoriasis	☐				
		Musculoskeletal		Psychiatric	
Genitourinary		Non-rheumatoid arthritis	☐	Depression	☐
Kidney stones	☐	Joint pain	☐	Anxiety	☐
STD/STI	☐	Swelling of joints	☐	Bipolar disorder	☐

Do you currently, or have you ever had, cancer? ☐ Yes ☐ No If yes, what kind(s)? _____

Genetics can sneak up on us in all kinds of ways... Which of the above medical conditions (including the eye-related ones) are in the family, and who specifically has them? _____
_____
_____

We've got to keep an eye on that stuff (pardon the pun...) to keep your eyes working their best. Also, some medications can affect the health and function of your eyes. What meds are you regularly taking? _____
_____
_____
Do you have any allergies to medications? Please list: _____
How about allergies in general, like seasonal or environmental allergies? Please list: _____
_____
Have you had any surgeries to your eyes (if so, we totally couldn't tell!)? If yes, what kind? _____

Do you ever rock some contact lenses? If yes, what kind? _____
If no, do you want to see if you are a candidate? They are nice to have for sports and social events! ☐ Yes ☐ No

Patient History Form

Health Testing

We. Love. Eyeballs!! …and we like to help keep them (and you!) healthy. We could bore you with the hundreds of ways we do that on a daily basis, but here's the bottom line: your eyes are our responsibility, and we take that responsibility very seriously. In order to take the best care of you though, we need to have a talk about health testing.

[i]PROTECT Retinal Screening: Retinal screening is the best way to detect the early onset of disease. To do this, we take a picture of the inside of the eye to have a permanent image to watch for subtle changes over time. We also scan the retinal tissue using light rays (like an X-ray for the back of the eye, but without any radiation). This scan shows what is happening deeper within the eye, even behind the tissue that can be seen with dilation alone. Retinal screening is completely non-invasive, and typically does not require the use of eye drops. For these reasons, in many ways this test is far superior to dilation alone.

This test is **strongly encouraged for all patients over the age of 40,** those with medical conditions like diabetes, high blood pressure, high cholesterol, a history of cancer, glaucoma, macular degeneration, retinal disease, or family members with those conditions. It is also strongly recommended for patients taking certain medications that can affect the eyes (like Plaquenil), patients presenting with symptoms like headaches, pressure in/around the eyes, seeing black spots or wavy lines, or those **patients that are new to the practice** or want the **most thorough examination possible**. The cost for this important screening test is only $39.

Dilation: Again, we care about the health of your eyes! For that reason, we are happy to provide a dilated fundus exam as part of our comprehensive eye examination, at no additional charge. Ever.

The drops that are used to dilate pupils require approximately 15-20 minutes to take effect and the eyes will remain dilated for 3-6 hours. During that time, it is normal to experience light sensitivity and blurred vision. Serious side effects rarely occur, but if you experience pain around the eyes or nausea, please notify the doctor immediately.

Would you like an [i]PROTECT Retinal Screening? ☐ Yes ☐ No Would you like a dilation? ☐ Yes ☐ No

SECOND SUPER-BORING STUFF ALERT!!! (Please initial each point, and sign below)

_____*Assignment of Benefit*: I authorize the assignment of benefits payable to Couture Vision for physician services and materials by government and/or any other private third party payer.

_____To comply with HIPAA guidelines, patients over the age of 18 will be their own responsible party. For patients under the age of 18, please provide the name of the guarantor: _____

As a courtesy, the friendly people at Couture Vision will do our best to interpret any insurance benefits that may be available to you. We do not claim to be experts in the ever-changing world of insurance, nor do we have advanced degrees in mathematics, or a crystal ball to tell us what the insurance companies will ultimately say. Also, we are human (allegedly…), and sometimes make mistakes. The estimates that we provide to calculate payments are just that…estimates. We will contact you immediately with any discrepancy between the estimate and the amount due.

_____*Statement of Financial Responsibility*: I understand that payment is due on the date of service, and that payments are based on *estimates* calculated using only information available at the time of service, and that the total payment due is therefore subject to change. I further understand that will be held responsible for payment of all co-payments, co-insurance, deductibles, and non-covered services.

To the best of my knowledge, the above information is true and correct.

Signed: _____ Date: _____
(Patient/guardian) (Relationship)

Patient History Form

HIPAA and your Privacy

We understand the importance of keeping your personal information private. Not only are we concerned about protecting your privacy because we aren't terrible people, we are also required by state and federal law to adhere to specific guidelines. Below is a condensed version of your rights as a patient under the Health Insurance Portability and Accountability Act of 1996, or HIPAA for short. We affectionately refer to this as the HIPAA[potamus] Act.

HIPAA[potamuses] are awesome, and here is what they do for you:

HIPAA[potamuses] are protective creatures and, in this context, limit who may see your private health information (PHI). This limits how we may use or disclose your information. Through this document, we intend to inform you of our legal duties with respect to your PHI, and explain our privacy policies.

Couture Vision may disclose your information for the following reasons:

- Treatment, continuity of care, or co-management
- Payment (relating to insurance, flex spending programs (FSA), health spending accounts (HSA), etc.)
- Overseeing your health care operations regarding evaluation and clinical outcome
- As required by law (i.e. court summons, etc.)
- Insurance claims or other purposes deemed necessary by your insurance

Your rights as a HIPAA[potamus] protected patient:

- Your medical records are yours. We just hold them for you. You have the right to review your records.
- You have the right to request copies of your medical records. Written authorization to release the information is required, and we have the right to charge you a reasonable fee to provide those copies.
- You have the right to know whom we are giving medical information.
- You have the right to request that we not release any information without your approval.
- You have the right to request that we amend your medical information. This request must be in writing, and an explanation for the amend request must be provided.

So that's it…the HIPAA[potamus] Act of 1996 in a nutshell! Please initial, sign, and date below, acknowledging that you have read and understand the intricacies of this majestic creature...err...Act. If you would like a detailed version of your privacy protections, a full version is available upon request, and we guarantee it is a lot less fun to read!

_____*Authorization for Release*: I authorize Couture Vision to release to my insurance carrier or its agents any information concerning care, advice, treatment, or materials provided to me for the purposes of administration, review, investigation, or evaluation of claim coverage and utilization of services. I authorize that a copy of this information is valid as the original. I will notify Couture Vision in writing of any information that I do not want released.

Signed: _____ Date: _____
(Patient/guardian) (Relationship)

I also give my permission to the fun people at Couture Vision to release any medical information to (if any):

Name: _____ Relationship: _____

Signed: _____ Date: _____

PS- To any insurance auditors reading our slightly snarky, condensed version of HIPAA, we hope you enjoyed the read. Regardless of tone, we do take privacy issues very seriously. We've just found that people actually READ our forms by making them more...well, readable. In fact, we think amusing forms should be made standard across the country! Can you imagine how much more fun filing your taxes would be?!?

PPS- Also, auditor, we know you probably need some more stylish glasses. The next time you're in Illinois, you know where to find us. HIPPA[potamuses] forever!