Littlefield eye associates

Patient Questionnaire

First Name: _____ Middle Initial:_____ Last Name: _____

Preferred Name (only if different than legal first name): _____ **Date of Birth:** _____/_____/_____

Social Security Number: _____-_____-_____ Circle One: **M** or **F** Prefered Number (Circle One): **HOME CELL WORK**

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

Address: _____ Apartment/Unit #: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Occupation: _____

Race: _____ Ethnicity (Circle One): Hispanic **OR** Non-Hispanic Preferred Language:_____ ☐ ***I choose not to specify**

Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about us? *Provider List* *Yellow Pages* *Internet Search* *Personal Referral - Name*: _____

Insurance Information (Fill in all applicable fields):

Vision Insurance: *VSP/METLIFE *EYEMED/SURENCY *SUPERIOR *HUMANA VISION *NVA * UNDER MY MEDICAL INS.

Policy Holder's Name: _____ Date of Birth:_____ Policy Holder's Last 4 of SS#: _____

Insured Relationship to Patient: **SELF** **SPOUSE** **PARENT**

Medical Insurance: _____ Plan Name: _____

Policy Holder's Name: _____ Date of Birth:_____ Policy Holder's Last 4 of SS#: _____

Insured Relationship to Patient: **SELF** **SPOUSE** **PARENT**

Insurance and Billing Policies

I certify that I, and/or dependent(s), have insurance coverage with the company above and assign directly to Littlefield Eye Associates, LLC all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. In addition, I understand that it is my responsibility to know and understand my insurance benefits. I authorize Littlefield Eye Associates, LLC to release information regarding my medical care to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Littlefield Eye Associates, LLC will file insurance claims with only those companies that we have contracted with. If you carry your own insurance through an alternate company, we ask that you pay for services and materials in advance and then submit the charges for reimbursement.

Patients are required to pay in full for services rendered at the conclusion of the visit. This would include copays, procedures (not covered by insurance), any materials (glasses, lenses, or contact lenses), and/or other unpaid balances.

By signing below, I acknowledge that I understand the above insurance and billing policies,

Signature: _____ Date: _____/_____/_____

Social History

*The questions below are required by your insurance company, if you would prefer to leave these questions blank and discuss with your Doctor in private please check here ☐

Do you smoke? **YES** or **NO** Do you drink alcohol? **YES** or **NO** Do you use illegal drugs? **YES** or **NO**

Medical, Ocular, and Family History

Date of last eye exam: _____ Do you wear glasses? **YES** or **NO** If yes, how old are they? _____

Do you wear contact lenses? **YES** / **NO** / **I AM INTERESTED**

Current Brand: _____ **Daily / 2 Week / Monthly / Rigid Gas Permeable-**How old are they? _____

Do you drive? **YES** or **NO** Do you work on a computer? **YES** or **NO** Are you pregnant or nursing? **YES** or **NO**

List all current medications (including over the counter and prescription): _____

_____

_____

List any allergies to medications: _____

_____

List all past surgeries: _____

_____

Do you currently have, or have you ever had any of the following?

Eyes

Blurred Vision	YES____	NO____
Dryness	YES____	NO____
Sandy or Gritty Feeling	YES____	NO____
Redness	YES____	NO____
Itching	YES____	NO____
Poor Night Vision	YES____	NO____
Light Sensitivity	YES____	NO____
Eye Strain	YES____	NO____
Blindness	YES____	NO____
Retinal Disease	YES____	NO____
Macular Degeneration	YES____	NO____
Floaters or Spots	YES____	NO____
Discharge from the eyes	YES____	NO____
Styes or Chalazion	YES____	NO____
Double Vision	YES____	NO____
Eye Pain/Soreness	YES____	NO____
Excess Tearing/Watering	YES____	NO____
Lazy Eye	YES____	NO____
Glaucoma	YES____	NO____
Cataracts	YES____	NO____

Ear, Nose, Throat

Allergies/Hay Fever	YES____	NO____
Sinus Congestion	YES____	NO____

Neurological

Headaches	YES____	NO____
Migraines	YES____	NO____
Seizures or Epilepsy	YES____	NO____
Stroke	YES____	NO____

Respiratory

Emphysema	YES____	NO____
Chronic Bronchitis	YES____	NO____
Asthma	YES____	NO____

Vascular/Cardiovascular

Diabetes-**TYPE**?____	YES____	NO____
High Blood Pressure	YES____	NO____
Artificial Heart Valve	YES____	NO____

Musculoskeletal/Autoimmune

Rheumatoid Arthritis	YES____	NO____
Arthritis	YES____	NO____
Lupus	YES____	NO____

Other

Cancer	YES____	NO____
HIV/AIDS	YES____	NO____
Hepatitis-**TYPE**?____	YES____	NO____
STD	YES____	NO____
Kidney Disease	YES____	NO____
Skin Condition	YES____	NO____

Please list any known eye disease or conditions: _____

Please list any additional conditions or elaborate on above if necessary: _____

_____

_____

_____

_____

Family History

Please check if anyone in your family has a history of the following:

Blindness	YES____	NO____
Cataracts	YES____	NO____
Glaucoma	YES____	NO____
Macular Degeneration	YES____	NO____
Retinal Disease	YES____	NO____
Retinal Detachment	YES____	NO____

Cancer	YES____	NO____
Diabetes	YES____	NO____
Heart Disease	YES____	NO____
High Blood Pressure	YES____	NO____
Kidney Disease	YES____	NO____
Lupus	YES____	NO____

Other: _____

Please leave the following section blank if you do not have an established Primary Care Physician

Medical Doctor: _____ Name of Practice or Hospital: _____

Address: _____ City: _____ State: _____