Patient History Questionnaire

IMPORTANT: To be reviewed at each appointment. All information is strictly confidential.

Last Name:_____ First name: _____ Middle:_____
Address:_____ City:_____ State:_____ Zip:_____
Home phone:_____ Work phone:_____ Cell:_____
E-mail address: _____ Fax #: _____
Communication Preference: **Home Phone Cell Phone Work Phone E-mail Fax**
Patient SS#: ____/____/____ Sex: M/F If a student, what school and grade: _____
Date of Birth:_____ Age ____ Work place: _____ Occupation: _____
Emergency contact person: _____ Phone number: _____
Marital Status: M S D Sep. Wid. Referred to us by whom? _____

Family Members: Spouse _____ Children _____
Bro/Sis (if pt. is a minor) _____
Parents _____
Ethnicity: Hispanic Native Hawaiian Not Hispanic or Latino Preferred Language: _____

Race: American Indian/Alaska native Asian Black/African American Hispanic Native Hawaiian White

Insurance Information

Prim. Insured name: _____ Employer:_____ SS# _____ DOB _____
Sec. Insured name: _____ Employer: _____ SS# _____ DOB _____
* Primary Care Physician: _____ Exam results sent to them? Y or N

Medical Information

How is your general health? _____
Do you take any medications for any of the following systems? (circle Y or N)

Gastrointestinal	Y/N	Nervous	Y/N	Endocrine	Y/N	Ear/Nose/Throat	Y/N
Urinary	Y/N	Blood/Lymph	Y/N	Cardiovascular	Y/N	Muscle/Bones	Y/N
Respiratory	Y/N	Integ/Skin	Y/N	Allergic/Sinus	Y/N	Mental/Psychiatric	Y/N
High blood pressure	Y/N	Headaches	Y/N	Diabetes	Y/N	which type? _____	
Nerve problems	Y/N	Arthritis	Y/N				

Please list your medications: _____
_____
_____
Allergies to Medications: _____
_____

Have you smoked in the past? Y/N Do you currently smoke? Y/N How much? _____
Do you drink alcohol? Y/N (Excess occasionally/Socially only)
Are you currently pregnant? Y/N (If so, when is your due date? _____)

Family Medical/Ocular History

(parents or siblings only)

High Blood Pressure	Diabetes	Retinal detachment	Cataracts	Lazy/Crossed Eye
Macular degeneration	Glaucoma	High Astigmatism	Arthritis	Poor Eyesight

Other eye diseases_____

Personal Eye Information

When was your last eye examination? _____. Did you get glasses, contacts, or neither?
What is the primary reason for today's visit? _____
What is your main complaint today? _____
Do you currently wear: Eyeglasses Contact Lenses (type and schedule _____)
Today, I want to get: Eyeglasses Sunglasses Computer Glasses Contact Lenses Eye Medical Treatment
Vision Exam only Driver's License Exam Special Testing
Have you had any eye surgery or recent eye injury? Y/N (date: _____)
Do you have: Cataracts /Macular Degeneration / Dry Eyes / Retinal Detachment / Glaucoma / Loss of Vision
Describe your eye or vision symptoms: _____

_____

_____

Consent to Treat

By my signature, I consent to treatment for myself or on behalf of this patient as their legal parent or guardian. I give my permission for the doctor and staff to examine, diagnose, and treat as deemed necessary or appropriate. I further sign that I am responsible for the payment of both services and materials that my insurance does not cover and understand that legal action will be taken if I do not financially satisfy my obligations.

_____ _____
Patient/Parent/Guardian Signature Date

Notice of Privacy Practice Summary

This notice is a summary of how your protected health information is used. For a full copy, see front desk assistant.
We use health information about you for treatment, to obtain payment, for administrative use, and to evaluate the quality of care you receive. We may use identifiable health information about you without your authorization for public health purposes, for auditing, for research studies, and for emergencies. We provide information when otherwise required by law such as for law enforcement as well. In any other situation, we will ask for your written authorization before using it. If you choose to sign an authorization, you may later revoke it to stop any future disclosures. We may be required to change our policies by law and these will be posted in the reception room along with the full disclosure.
Your rights:

- request a restriction on certain uses and disclosures of your info as provided by 45 CFR 164.522
- obtain a paper copy of the notice of privacy practices upon request
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health info as provided in 45 CFR 164.528
- request communications of your helath info by alternative means or at alternative locations
- revoke your authorization to use or disclose health info except to the extent that action has already been taken

If you are concerned that we have violated your privacy rights, or you disagree with a decision that we made about access to your records, you may contact the person listed below. You also may send written complaints to the U.S. Department of Health and Human Services. The person listed below can provide you with this address.

Our Legal Duty:
We are required by law to protect the privacy of your information, provide this notice about our information Practices, and follow the information practices that are described in this notice. If you have questions or any complaints, please contact Jeffrey C. McClain, OD, 1132 W. Clark Blvd., Murfreesboro, Tn. 37129. Phone (615) 893-0149 or email jeffmcclain59@gmail.com.

I acknowledge that I have reviewed the Notice of Privacy Practice which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

_____ _____ _____ _____
Signature of Patient or Legal Guardian Date Witness Date