# Patient History Questionnaire

**First Name:**_____ **Last Name:**_____

**Address:** _____ **City:**_____ **State:** ____ **Zip:**_____

**Date of Birth:**_____ **Phone #:**_____**Email:**_____

**Emergency Contact:**_____**Phone #:**_____

**Date of Last Eye Exam:**_____**Occupation:**_____**Employer:**_____

## MEDICAL HISTORY

**Check all that apply to you:**

| | | |
|---|---|---|
| ☐ High Blood Pressure | ☐ High Cholesterol | Diabetes: ☐ Type 1 ☐ Type II |
| ☐ Thyroid issues | ☐ Headaches/Migraines | ☐ Cancer |
| ☐ Respiratory issues | ☐ Auto-immune disorder | ☐ Other: |

**Current Medications:** _____

**Drug Allergies:**_____

## EYE HISTORY

**Check all that apply to you:**

| | | | |
|---|---|---|---|
| ☐ **Glaucoma** | ☐ **Macular Degeneration** | ☐ **Cataracts** | ☐ **Retinal Detachment** |
| Other: | | | |

**Check all that apply to your family history:**

| | | | |
|---|---|---|---|
| ☐ **Glaucoma** | ☐ **Macular Degeneration** | ☐ **Cataracts** | ☐ **Retinal Detachment** |
| Relation: | Relation: | Relation: | Relation: |

**Do you wear glasses?** ☐ Yes ☐ No **If so, for what?** ☐ Far ☐ Near ☐ Both

**Do you wear contacts?** ☐ Yes ☐ No **If so, what brand do you wear?** _____

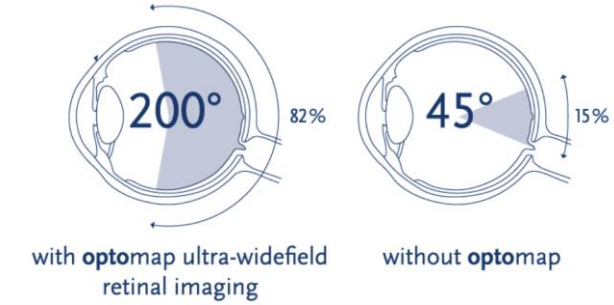
**Please provide any Ocular Surgeries with date(s):**_____

**Any concerns or questions for the doctor?** _____

optomap®
ultra-widefield retinal imaging

**What is an Optomap?**

- An ultra-widefield image that provides a 200 degree high resolution view of the back of the eye **without** the need of dilation drops




**What are the benefits of Optomap retinal imaging?**

- Early detection of sight-threatening conditions such as **retinal detachments, glaucoma, or macular degeneration**
- Early detection of systemic diseases such as **cardiovascular disease, stroke, or cancer**
- Allows eye doctor to precisely track changes over time better than standard eye exams
- Although we recommend dilation as well, it may alleviate the need for dilation
- Takes less than 1 min per eye

Vision insurance covers a basic eye exam and mostly likely does not cover advanced screening tools such as Optomap. We have invested in this state of the art technology because we believe it is in our patients' best medical interest to have this retinal scan. **The cost of the Optomap is $39.**

☐ **Yes, I would like an Optomap performed today so the doctor can further assess my retinal health**

☐ I would like to discuss further with the doctor

☐ No, thank you

**What is dilation?**

- Dilation, which is part of a comprehensive eye exam, is the use of pharmaceutical eye drops to dilate the pupils to allow the doctor to assess the entirety of the back of the eyes
- ***Side effects of dilation can last 1-3 hours and can include increased sensitivity to light, which may make driving more difficult, and decreased focusing/reading***

☐ Yes, I would like to be dilated today

☐ No, I don't want to be dilated today

# Guilderland Vision Care Disclosures:

**HIPAA Privacy Policy:**

I understand Guilderland Vision Care may not use nor disclose protected health information to another party, unless it is to permit Guilderland Vision Care to perform administrative duties, provide me with eye care services/referrals and products, process my vision and health benefit claims and communicate with me regarding vision care services provided by Guilderland Vision Care. I can be assured that Guilderland Vision Care does not sell my protected health information of any kind, and/or the vision services and products that I have received to a third party for such party's own use. I understand I can receive a more detailed HIPAA privacy policy upon request.

I give Guilderland Vision Care permission to:

| Leave *appointment* information by: | Leave *medical* information by: |
|---|---|
| ☐ Phone call<br>☐ Text<br>☐ Email<br>☐ Voicemail<br>☐ Mail<br>☐ Another Person (list below) | ☐ Phone call<br>☐ Text<br>☐ Email<br>☐ Voicemail<br>☐ Mail<br>☐ Another Person (list below) |

Other person(s) authorized to communicate with Guilderland Vision Care:_____

**Patient Financial Responsibility:**

I understand that Guilderland Vision Care will be billing my insurance company. I understand that it is my responsibility to read and understand my insurance coverage. If, for any reason, my insurance company does not pay Guilderland Vision Care for services provided, I agree to pay Guilderland Vision Care in full for all services rendered.

**Explanation of Coverage:**

Vision insurance is for routine eye exams which includes an annual eye exam, with refraction, to evaluate the health of the eyes and determine the need for glasses and/or contacts. These plans may also provide benefits for the purchase of glasses and/or contacts.

Medical insurance provides coverage for diagnostic testing and medical treatment for a medical diagnosis such as glaucoma, macular degeneration, diabetes, hypertension, dry eye, conjunctivitis, cataracts, etc. Medical insurance does not cover the cost of a refraction ($50) and the patient is responsible for this fee.

Until a routine eye exam has been completed, it is not possible to determine if a medical diagnosis exists that may require additional testing. If a medical diagnosis is identified, Guilderland Vision Care is required by our vision and medical contractual obligations to submit the claim(s) to the appropriate carrier(s). In the event we do not participate with your insurance plan we will provide an itemized receipt so that you may file with your carrier for any out-of-network benefits.

**Release of Liability for Internal Eye Health Exam:**

I have been informed that a thorough internal examination (dilation/Optomap) is integral to an eye exam and without it, serious eye and systemic diseases indicators can be missed that can lead to blindness and/or serious health issues.

**By signing below, I understand and agree to the above disclosures:**

Signature:_____ Date:_____