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NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME#:_____ CELL#:_____ WORK#_____

EMAIL ADDRESS:_____

SS#_____ SEX: MALE / FEMALE MARITAL STATUS: S / M / W / D

REFERRED TO OFFICE BY: ☐ WEBSITE ☐ INTERNET ☐ FAMILY/FRIEND ☐ MAILER

☐ HEALTH FAIR ☐ TV ☐ INSURANCE CO. ☐ OTHER_____

EMERGENCY CONTACT INFORMATION

NAME:_____ RELATION TO PATIENT:_____

ADDRESS: _____ DATE OF BIRTH:_____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME#:_____ CELL#:_____ WORK#_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payments to Akler Eye Center for services rendered under their supervision. I understand that I am financially responsible for any balance unpaid or not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Akler Eye Center to release any medical or incidental information that may be required for either medical care or in the processing application for financial benefit.

MEDICARE

I certify that the information given by me is correct. I authorize release of all medical records on request. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be valid as the original.

_____ _____

Patient Signature Date

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Nickname: _____ Date of Birth: ____/____/_____

Primary Care Physician: _____ Referring /Specialty Dr. _____

Pharmacy: _____ Location(street & city) _____

Race: ◻ American Indian or Alaska Native ◻ Asian ◻ Black or African American

◻ Native Hawaiian or Other Pacific Islander ◻ White

Allergies: Reaction Severity

_____ _____ mild / moderate / severe

_____ _____ mild / moderate / severe

_____ _____ mild / moderate / severe

_____ _____ mild / moderate / severe

Past Ocular History: (Please mark all that apply)

◻ Overall Healthy
◻ Amblyopia (Lazy eye)
◻ Aphakia
◻ Astigmatism
◻ Cataracts
◻ Diabetic Retinopathy
◻ Dry Eyes
◻ Glaucoma
◻ Hyperopia (Far sighted)
◻ Iritis
◻ Keratoconus
◻ Macular Degeneration
◻ Myopia (Near sighted)
◻ Optic Neuritis
◻ Retinal Detachment

Other_____

Ocular Surgeries: (Please mark all that apply)

◻ No prior ocular surgery
◻ Blepharoplasty
◻ Cataract Surgery
◻ Corneal Transplant
◻ Foreign Body Removal
◻ Retinal Laser Surgery
◻ LASIK
◻ PRK / Epi-LASIK
◻ Punctal Plugs
◻ RK
◻ Strabismus Surgery
◻ Trabeculectomy
◻ Vitrectomy

Other_____

Ocular Significant Illnesses: (Please mark all that apply)

◻ Overall Healthy
◻ AIDS
◻ Diabetes
◻ Rheumatoid Arthritis
◻ Herpes
◻ HIV Positive
◻ Hypertension
◻ Hypothyroidism
◻ Lupus
◻ Multiple Sclerosis
◻ Sjogrens
◻ Graves Disease
◻ Hyperthyroidism

Other_____

Current Eye Medications: (Please list)

_____

_____

_____

Systemic Illnesses:

◻ No history of illnesses
◻ Anemia
◻ Arthritis
◻ Arrhythmia
◻ Asthma
◻ Bleeding Disorder
◻ Cancer
◻ Thyroid Disease
◻ Congestive Heart Failure
◻ COPD
◻ Diabetes
◻ Eczema
◻ Fibromyalgia
◻ Headache
◻ Hearing Loss
◻ Hepatitis
◻ High Blood Pressure
◻ High Cholesterol
◻ HIV
◻ Kidney Disease
◻ Kidney Stones
◻ Liver Disease
◻ Lung Disease
◻ Lupus
◻ Migraine
◻ Polymyalgia
◻ Psychiatric Disorder
◻ Skin Cancer
◻ Stroke

Other_____

General Surgeries / Operations: (Please list)

_____

_____

_____

Please continue on the back side of this page →

Current Other Medications: (Please list)

_____

_____

_____

Infections: (Please mark all that apply)

- ◻ Overall Healthy
- ◻ Chicken Pox
- ◻ Hepatitis A / B / C
- ◻ Herpes Simplex
- ◻ Herpes Zoster / Shingles
- ◻ Histoplasmosis
- ◻ HIV / AIDS
- ◻ Meningitis
- ◻ MRSA
- ◻ Syphillis
- ◻ Toxoplasmosis
- ◻ Wound Infection

Other_____

Family History:

- ◻ Arthritis
- ◻ Blindness
- ◻ Cancer
- ◻ Cataracts
- ◻ Diabetes
- ◻ Glaucoma
- ◻ Heart Disease
- ◻ High Blood Pressure
- ◻ Kidney Disease
- ◻ Lazy Eye
- ◻ Macular Degeneration
- ◻ Retinal Disease
- ◻ Stroke
- ◻ TB

Other_____

Social History: (Please mark all that apply)

Smoking: ◻ current every day smoker ◻ current some day smoker ◻ former smoker ◻ never smoked

Alcohol Use: ◻ Yes ◻ No If yes how much and how often?_____

Drug Use: ◻ Yes ◻ No If yes what and how often?_____

Review of Systems: (Please mark all that apply)

Eyes
- ◻ Previous Surgery
- ◻ Contact Lens
- ◻ Pain
- ◻ Double Vision
- ◻ Glaucoma
- ◻ Cataracts
- ◻ Macular Degeneration
- ◻ Dry Eyes
- ◻ Flashes
- ◻ Floaters

Ear, Nose, and Throat
- ◻ Hard of Hearing
- ◻ Ringing in Ears
- ◻ Vertigo

Cardiovascular
- ◻ Chest Pain
- ◻ Dizziness
- ◻ Fainting Spells
- ◻ Shortness of Breath
- ◻ Irregular Heart Beat
- ◻ Difficulty Lying Flat

Constitutional
- ◻ Fatigue / Weakness
- ◻ Fever
- ◻ Weight Gain / Loss

Respiratory
- ◻ Cough
- ◻ Congestion
- ◻ Wheezing
- ◻ Asthma

Gastrointestinal
- ◻ Heartburn
- ◻ Nausea / Vomiting
- ◻ Jaundice / Hepatitus

Genito-Urinary
- ◻ Pain / Difficulty
- ◻ Blood in Urine
- ◻ History of Kidney Stones
- ◻ History of STD's

Psychiatric
- ◻ Anxiety / Depression
- ◻ Mood Swings
- ◻ Difficulty Sleeping

Endocrine
- ◻ Increased Thirst
- ◻ Increased Hunger
- ◻ Increased Urination
- ◻ Increased Sweating
- ◻ Fingernail Changes

Blood / Lymphnodes
- ◻ Easy Bruising
- ◻ Gums Bleed Easy
- ◻ Prolonged Bleeding
- ◻ Heavy Aspirin Use

Musculo/Skeletal
- ◻ Stiffness
- ◻ Arthritis
- ◻ Joint Pain / Swelling

Skin
- ◻ Rash / Sores
- ◻ Lesions
- ◻ Hives / Eczema

Neurological
- ◻ Seizures
- ◻ Weakness / Paralysis
- ◻ Numbness
- ◻ Tremors

Immunologic
- ◻ Hives
- ◻ Itching
- ◻ Runny Nose
- ◻ Sinus Pressure

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Cancellation Policy/No Show Policy for Doctor Appointments and Surgery

1. *Cancellation/No Show Policy for Doctor Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty-dollar ($50.00) fee; this will not be covered by your insurance company.

2. *Scheduled Appointments*

We understand that delays can happen however we must try to keep the other patients and doctor on time. **If a patient is 15 minutes past their scheduled time, we have the right to reschedule the appointment.**

3. *Cancellation/No Show Policy for Surgery*

Due to a large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office. If surgery is not cancelled at least 5 days in advance, unless there is a compelling reason (eg.acute illness), you will be charged a seventy-five-dollar ($75.00) fee; this is not covered by your insurance company.

4. *Account Balances*

We will require that patients with self-pay balances, insurance deductibles and co-pays do bring their account balance to zero (0) prior to receiving further services by our practice. Patients who have questions about their bills or would like to arrange a payment plan may call and speak to a business office representative who can address their concerns.

Patients with balances over $100.00 must make payment arrangements prior to future appointments being made.

Print Patient Name: _____ Date: _____

Signature of Patient/Guardian: _____ Date: _____