

OPTYX

PATIENT QUESTIONNAIRE FORM

DATE: _____

LAST NAME: _____ FIRST NAME: _____ DOB: _____ AGE: _____
 ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
 HOME phone #(____) _____ CELL phone#(____) _____ WORK#: _____
 E-mail address _____ Occupation _____ GENDER _____
 Medical Doctor: _____ Referred By: _____ Last Eye Exam: _____

REVIEW OF SYSTEMS: Please check YES or NO if YOU have any of the following & specify the condition:

	Y	N		Y	N
Constitutional(Fever, weight loss)			Neurological Problems(Migraines, Seizures)		
Breathing(Asthma)			Allergic/Immune(Lupus)		
Skin Problems			Ears/Nose/Throat(Dryness,Sinus)		
Blood Problems(Cholesterol)			Psychiatric(Depression)		
Genital, Kidney, Bladder			Musculoskeletal(Arthritis)		
Endocrine(Thyroid, Diabetes)			Cardiac(Blood Pressure,Vascular Disease)		
Gastrointestinal Problem(Diarrhea,Constipation)					

Please CIRCLE any problems you may have or had in the past:

Blurred vision	Eye pain	Dryness	Eye infection	Glaucoma
Double vision	Eye Fatigue	Itching	Styes/lid infection	Macular degeneration
Loss of vision	Lazy eye/eye turn	Redness	Light sensitivity	Cornea problems
Flashes/Floaters	Distortion/Halos	Burning	Excess tearing	Other: _____

PAST:	Illnesses	Hospitalizations	Surgeries
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

DO ANY OF YOUR BLOOD RELATIVES HAVE ANY OF THESE CONDITIONS:

Please circle and indicate relationship

EYES	MEDICAL
Cataract	Diabetes
Macular Degeneration	High Blood Pressure/Heart Disease
Retina Disease	Thyroid Disease
Blindness	Auto Immune
Glaucoma	Cancer, if yes, type

MEDICATIONS: (Rx and over-the-counter)

ALLERGIES, if YES, please LIST

Are you pregnant or nursing? YES NO

SOCIAL HISTORY:

Do you drink Alcohol? Y/N If YES, how much? _____ Do you Smoke? Y/N If YES, how much? _____

Do you or have you used recreational drugs? YES NO If YES, specify: _____

Have you ever been exposed to or infected with: ___Gonorrhea___Hepatitis___HIV___Syphilis___

INSURANCE ASSIGNMENT AND RELEASE

I, certify that I, and/or my dependant(s), have insurance coverage with _____

And assign directly to Optyx all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Optyx may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Patient Signature: _____ Date: _____

Social Security No: _____

*****If you are NOT the PRIMARY insurance holder, please complete the information below for the PRIMARY:**

Name:

DOB:

Address:

Relationship:

ACKNOWLEDGEMENT OF RECEIPT AND GENERAL CONSENT

I acknowledge that I have reviewed a copy of OPTYX Notice of Privacy Practice. I further consent to the release of my health information for purposes of treatment, payment and health care operations and as authorized or required by law under the circumstances described in the Notice of Privacy Practices.

Patient Signature: _____ Date: _____

If you are someone OTHER than the patient preparing this form, please print your name and indicate relationship:

Preparer Name: _____ Relationship to Patient: _____

For Returning Patients: There has been NO change in information since my last visit: _____ Initials _____ Date