ILLINOIS EYE CARE CENTER

Hoffman Estates

Palatine

Schaumburg

Medical History Interview

To comply with medical record requirements, please complete the following information

First name ______________________ MI____

Last name ______________________

Address ______________________

City ______________________ Zip__________

Home Phone ______________________

Work Phone__________________ Cell ______________

E-mail Address ______________________

Marital Status ______________________

Name of spouse ______________________

Responsible party if patient is a minor (under 18) ______________

Today's date ______________________

Date of birth ______________________ Age__________

Male____ Female ____

Social Security # ______________________

Occupation ______________________

Employer ______________________

How did you hear about our office? ______________

Has any member of your household had an exam here? ☐Yes ☐No

Name ______________________

What is your reason for today's eye exam?

_____comprehensive eye exam
_____blur at distance
_____blur at near
_____double vision
_____computer strain
_____headache
_____migraine
_____glaucoma
_____lazy eye
_____red eyes
_____flashes/spots
_____tears/discharge
_____eye pain/discomfort
_____itching
_____broken glasses
_____contact lenses
_____trauma

Have you had an eye injury? ☐Yes ☐No If yes, explain ______________________

Have you had eye surgery? ☐Yes ☐No If yes, explain ______________________

How old are your glasses?__________

Are you interested in Contact Lenses? ☐Yes ☐No

If you are presently wearing contacts, what type? ☐Gas Perm ☐Soft ☐Disposable ☐Daily ☐Bi-Weekly ☐Monthly

Are you interested in Lasik surgery? ☐Yes ☐No

Brand______________________

Medical History

Do you have, or have you ever been treated for:

_____diabetes Type 1 or Type 2
_____high blood pressure
_____heart disease
_____stroke
_____stomach problems
_____thyroid problems
_____arthritis/joint pain
_____kidney/urinary
_____STD
_____cancer
_____HIV
_____headache
_____breathing problems
_____depression/anxiety
_____sinus/allergy
_____skin condition
_____hearing loss

List any other medical conditions or surgeries: ______________________

Do you take any **medications**? ☐Yes ☐No If yes, list ______________________

____

Do you have any allergies? ☐Yes ☐No If yes, explain ______________________

Are you now pregnant or nursing? ☐Yes ☐No

Do you smoke? ☐Yes ☐No

Do you drink alcohol? ☐Yes ☐No

Do you have a history of drug use? ☐Yes ☐No If yes, explain ______________________

Please list the people in your family who have the following medical problems:

__________diabetes
__________arthritis
__________glaucoma
__________blindness
__________high blood pressure
__________sickle cell disease
__________macular degeneration
__________cancer
__________heart disease
__________retinal disease
__________crossed eyes
__________other

(over)

Insurance Authorization

It is understood that the undersigned patient is eligible for benefits under this plan. Any quote of benefits is just an estimate provided to us by your insurance company. Payment will not be determined until the claim is received. Therefore, we are unable to guarantee any quote of benefits. In the event the patient is not eligible for coverage, has not met their deductible, insurance does not pay as expected, or the insurance company does not respond within 30 days of submitting the claim the patient or responsible party is ultimately responsible for any unpaid balance. There will be an additional fee of $20.00 for any claim we have to turn over to our collection agency.

Patient Signature ______________________________ Date of Service ______________

Responsible Party ____

Signature ______________________________ Date of Service ______________

Contact Lens Policy

Most insurance companies cover for a **Standard Eye Examination** only. This includes an assessment of the overall health of the eye and a prescription for glasses.

Examination for contact lenses is generally not covered by most insurance companies, and the following additional tests are necessary in order to determine a precise fit and proper contact lens prescription and to determine the eye's ability to safely wear contact lenses.

- Assessment and health of your cornea.
- Training of insertion and removal for new wearers.
- Keratometry - measures the central curve of the eye - needed to determine lens shape, size, and power.
- Slit lamp biomicroscopy - microscopic evaluation of the front of the eye to rule out any conditions that could interfere with lens wear such as infection, allergies, inflammation, or scarring.
- Tear volume & tear quality assessment.
- Examination with your present contact lenses.
- Determination of the contact lens prescription - different from the glasses prescription; the power needed in the lens to provide maximum vision.
- Contact lens design & analysis of fit - evaluation of the lens on the eye to ensure a healthy fitting relationship; specifically, proper centration and movement when blinking.

There is an additional professional fee for the contact lens evaluation and fitting. The fee varies depending on the complexity of the prescription, the type of contact lens and the services necessary for the most optimal fit.

Acknowledgement of the Above Contact Lens Policy and Fitting Fee

Patient Signature ______________________________ Date of Service ______________

Responsible Party ____

Signature ______________________________ Date of Service ______________

Acknowledgement of Receipt of Privacy Practices

I, ______________________ have reviewed/received a copy of Illinois Eye Care Centers Notice of Privacy Practices.

Print Name ______________________ Signature ______________________ Date _______