Patient History Questionnaire

Please answer all questions. Email address ____
Last name ____________________First name ________________MI___(nick name)________
Address___________________________ Apt______ City _____________State ____Zip _____
Telephone (H) ____________________ (W) _____________________ (Cell) ______________
PID or SSN(last 4 Digits)___________________ DL ________________ Birth date__________
Employer ______________________________ Occupation ____________________________
Emergency Contact/Telephone Number ____________________________Single/Married/Other
Date of last eye exam ________________ Dilated ____________ Today's Date_____________

Insurance Information

Primary Insured Personal ID __________________ Group_______ Insurance Name________
Address_____________________________________ Insurance Phone ____________________
Insured's Name _____________________ Birth Date __________ Relationship _____________
Address ____ Phone __________________
Secondary Insured Information: ID _______________ Group_______ Insurance Name______
Insured's Name _____________________ Birth Date __________ Relationship _____________

Medical Information

What is your general health? ____
Do you have any problems with any of these systems? (please circle all that apply)

Gastrointestinal	Y/N	Nervous	Y/N	Mental	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Endocrine	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Blood/lymph	Y/N
Respiratory	Y/N	Skin	Y/N	Allergic/immunologic	Y/N

Please Explain ____
Diabetes Y/N Type _______________________________ Date of diagnosis _______________
Allergies Y/N Allergic to what? _____________________ What happens? _________________
Medication allergy Y/N What Happens? ________________________________Headaches Y/N
Other health problems ____
Current medication(s) ____
Have you had any operations? Y/N Kind?_____________________________ When?_________
Do you use cigarettes/tobacco? _________ Alcohol? _____________ Other substance(s)? _____
Name of family doctor ________________________________Date of last visit ______________
Date of last tetanus shot ______________________________

Family History

High blood pressure	Y/N	Relation_______	Macular degeneration	Y/N	Relation_____
Diabetes	Y/N	Relation_______	Retinal detachment	Y/N	Relation_____
Glaucoma	Y/N	Relation_______	Cataracts	Y/N	Relation_____

Other eye condition(s) Y/N What kind? __________________________________Relation_____

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Personal Eyecare Information

Are you interested in corrective Eye surgery? ______________________________________
Have you had any eye operations? Y/N Type_______________________ Date ____________
Have you had an eye injury? Y/N Kind _______________________Date ____________
Do you have glaucoma? Y/N Cataracts? Y/N Dry eyes? Y/N Blurred vision? Y/N
Other eye problems? Y/N What kind? ____
Do you wear glasses? Y/N Contact lenses? Y/N Type _____________________________
Additional information ____
Whom may we thank for referring you? ____
Doctor's initials

Patient Financial Responsibility/ Insurance Signature on File

 I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize this vision care provider to apply for benefits on my behalf for any services or materials furnished. I authorize payment of these benefits directly to Dr. Michael Lipman. I assign my benefits from my insurer be made directly to the vision care provider and authorize any holder of medical information about me to release to the Medical Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. I agree to assume responsibility of full payment pending any remaining balance that is not covered by my insurer.

Acknowledgement of Receipt of Notice of Privacy Practices **Dr. Michael Lipman**
Connie Everett, Privacy Officer **949-833-8446**

 I herby acknowledge that I received a copy of this medical practice Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.
A copy of any amended Notice of Privacy Practices may be delivered by e-mail or USP service. This medical facility may leave a message on my phone message service at contacts given phone numbers, concerning my medical treatment as needed, unless otherwise indicated: ___________
____
I understand this medical facility uses email for communication for appointments, monthly newsletter, birthday, survey, special discount, and yearly recall for eye health exam, unless otherwise indicated: ____
I have an option to opt out at anytime.

Members Signature and Date____ Date _________
(Lifetime Patient Signature on File)

If not signed by the patient, please indicate relationship:
 parent or guardian of minor patient guardian or conservator of an incompetent patient
 beneficiary or personal representative of deceased patient
Print Name of Patient: ____