UPTOWN FAMILY **VISION**
Jean Nham, O.D.

Welcome to our office!

How did you choose our office?
☐ Friend or Relative ☐ Another Doctor
☐ Insurance List ☐ Saw Sign/Building
☐ Online Search. If so, where? _____
☐ Other: _____

Patient Information

First: _____ Middle: _____ Last: _____

Parent's name (if minor): _____

Street: _____

City, State, ZIP: _____

Date of Birth: _____ Age: ____ Sex: M F Email: _____

Phone #1: _____ (home/work/cell) Phone #2: _____ (home/work/cell)

How do you prefer to be contacted? (circle one) Home # Work # Cell # Email Text

Employer (or School): _____ Occupation (or Grade): _____

FINANCIAL POLICY: **Payment Options:** Cash, Check, Visa, MasterCard, American Express, Discover, CareCredit
Please note: It is customary to pay for professional services when rendered. However, if you have a medical problem then we will bill your insurance on your behalf. A refraction is a measurement of the lens power necessary to prescribe glasses or other corrective lenses. Most medical insurance plans, including Medicare, do not cover routine refractions or routine eye exams (when no medical eye problem is known or suspected). Medicare, and most other insurance plans, insists that we charge separately for that portion of the examination, since it is not a covered service. You will receive an explanation of benefits from them itemizing your responsibilities. You will be responsible for any co-payments, deductibles or non-covered services as determined by your insurance company. If you have a separate plan that covers routine or annual eye examinations and/or glasses, please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan. We will bill your vision plan as above. In accordance with our contract and with your insurance provider, we are responsible for collecting, and you are responsible for paying, co-payments at the time of service.

Initial _____

AUTHORIZATION TO BILL INSURANCE: I authorize Uptown Family Vision to bill my insurance carrier on my behalf. I request that payment of authorized insurance benefits be made to this clinic for any services furnished me by this doctor/clinic. I understand that I am financially responsible for any balance not covered by my insurance carrier, and that a quotation of benefits is not a guarantee of coverage. A copy of this signature is valid as the original. I authorize any holder of medical information about me to release to my medical insurance carrier any information needed to determine the benefits payable for related services for myself and/or my dependents.

Initial _____

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT: We keep a record of the health care services we provide to you. You may request a copy of your medical record in writing. We will not disclose your record to others unless you direct us to do so or unless legal authorities authorize or compel us to do so. You may request a copy of your medical record or get more information by contacting the Uptown Family Vision Privacy Officer. Our Notice of Privacy Practices is available at the reception desk. The Notice describes in greater detail how your health information may be used or disclosed, and how you can access your information. You are entitled to a copy of this Notice and it is available at your request.

I acknowledge the Notice of Privacy Practices has been offered to me and is readily available in accordance with the Health Insurance Portability and Accountability Act.

Patient/guardian: _____ Date: _____

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Please complete the following form as thoroughly as possible. The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Name: _____ **Date:** _____

Patient Medical History

Current Medications (Rx or Over-The-Counter) (List name of medications, including eye drops, vitamins & birth control pills, dosages, and frequency.)

_____

_____

Allergies to medications? ☐ Yes ☐ No If so, what medications? _____

_____

Are you currently pregnant or nursing? ☐ Yes ☐ No

Have you ever been diagnosed or treated for any of the following health problems? (please circle)

Constitution
Fatigue
Fevers
Unusual weight loss/gain
Cancer

Ear/Nose/Throat
Hearing loss
Sinusitis
Throat Infections

Neurological
Migraines
Multiple sclerosis
Epilepsy
Cerebral palsy
Tumor
Autism spectrum disorder

Psychiatric
Depression
Attention deficit
Anxiety disorder
Bipolar disorder

Cardiovascular
High blood pressure
High cholesterol
Stroke/CVA
Heart disease
Vascular disease
Congestive heart failure

Respiratory
Asthma
Bronchitis
Emphysema

Gastrointestinal
Crohn's Disease
Colitis
Celiac Disease

Genitourinary
Kidney disease
Prostate disease
STD – herpetic/chlamydia

Muscular/Skeletal
Osteoarthritis
Fibromyalgia
Muscular dystrophy
Ankylosing spondylitis

Integumentary
Eczema
Rosacea
Psoriasis
Herpes simplex
Herpes zoster

Endocrine
Diabetes, type II
Diabetes, type I
Thyroid

Hematologic/Lymphatic
Anemia
Ulcer

Allergy/Immune
Environmental allergies
Rheumatoid arthritis
Lupus
Sjogren's syndrome

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Please complete the following form as thoroughly as possible. The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Name: _____ **Date:** _____

Patient Eye History

Date of Last Eye Exam: _____

By Whom? _____

Have you had any eye-related surgeries of any kind?
☐ Yes ☐ No Explain _____

_____

Have you ever experienced, been diagnosed or treated for any of the following?

☐ Blurry Vision
☐ Cataracts
☐ Crossed eye/Eye turn
☐ Eye Infections
☐ Flash of light
☐ Glaucoma
☐ Headaches
☐ Itchiness
☐ Macular Degeneration
☐ Retinal Detachment
☐ Tearing
☐ Uncomfortable glasses
☐ Other eye disorders: _____
☐ Burning
☐ Corneal Abrasions
☐ Double Vision
☐ Eye Injury
☐ Floaters/Spots
☐ Grittiness
☐ Iritis/Uveitis
☐ Lazy Eye
☐ Occasional dryness
☐ Sunlight Sensitivity
☐ Trouble at night

Do you use…

Cigarettes or tobacco?	☐ Yes	☐ No
Alcohol?	☐ Yes	☐ No
Other substances?	☐ Yes	☐ No

Hobbies _____

_____

Family Medical/Eye History

Do you have a family medical history of any of the following? (check all that apply and indicate mother or father's side):

	Relationship (Mother's or Father's side)
Blindness	☐ _____
Cataracts	☐ _____
Corneal Problems	☐ _____
Diabetes	☐ _____
Glaucoma	☐ _____
Heart Disease	☐ _____
Lazy Eye	☐ _____
Macular Degeneration	☐ _____
Retinal Problems	☐ _____

Lifestyle Questions

Do you…(check all that apply):

☐ …use digital devices on a regular basis? If yes, how many hours per day? _____hrs/day
☐ …think you might benefit from thinner, lighter lenses?
☐ …prefer NOT to wear glasses at times?
☐ …spend time outdoors? How often? ___hrs/week
☐ …participate in vision-related sports or other activities? If yes, please specify: _____

_____

_____