LOMAN
EYE CARE

Loman Eye Care
"Protecting the Gift of Sight"

Patient History Questionnaire

Date_____

Name: Last_____ First_____ (Preferred)_____ MI____ D.O.B_____

Address_____ City _____Zip Code_____ Sex ☐M ☐F

Telephone: (Home)_____ (Work)_____ (Cell)_____

SS#_____-_____-_____ Do you prefer to receive calls at: ☐Home ☐Work ☐Cell Text ok: ☐Yes ☐No

Email Address_____

Occupation_____Employer_____

Emergency contact_____ Relationship to patient_____ Phone #_____

Date of last eye exam_____ Doctor/Location_____

Whom may we thank for referring you? _____

Medical Insurance Information

Name of Insured (person who carries the insurance) _____

Insured's SS#_____-_____-_____ Insured's D.O.B. _____Relationship to patient_____

Insured's Employer _____

Name of Vision Insurance Provider, if known (ex. VSP, Davis etc)_____

Responsible Party

Name of person responsible for this account_____ Relationship to patient_____

Ph#: _____ Address (if different from above) _____

_____

Signature of Patient (or parent if a minor) X_____ Date_____

Personal Eye Information

Do you currently wear glasses? ☐No ☐Yes - how old are your present glasses?_____

Are they your current prescription? ☐No ☐Yes Do you wear sunglasses? ☐No ☐Yes

Do you have problems with night vision? ☐No ☐Yes Do you use a computer? ☐No ☐Yes

Do you have problems with glare? ☐No ☐Yes

What hobbies/sports do you participate in?_____

Do you wear contact lenses? ☐No ☐Yes – brand_____

If NO: Are you interested in wearing contacts at this time? ☐No ☐Yes

Medical Information

How would you describe your general health: ☐Excellent ☐Good ☐Fair ☐Poor

Are you **ALLERGIC** to any Medications? ☐No ☐Yes:_____

Do you have problems with: (if yes, please circle or write in)

☐No ☐Yes Eye- *glaucoma, macular degeneration, blindness, other*_____
☐No ☐Yes Cardiovascular- *heart disease, high blood pressure, other*_____
☐No ☐Yes Endocrine- *diabetes, thyroid, other*_____
☐No ☐Yes Genital, Kidney and Bladder- *infections, other*_____
☐No ☐Yes Ear, Nose and Throat- *sinus disorder, chronic cough, other*_____
☐No ☐Yes Psychiatric- *anxiety, depression, ADHD, schizophrenia, other*_____
☐No ☐Yes Musculoskeletal- *arthritis, back pain, other*_____
☐No ☐Yes Allergic/Immunologic- *lupus, hay fever, rheumatoid arthritis, other*_____
☐No ☐Yes Skin- *rosacea, skin cancer, psoriasis, other*_____
☐No ☐Yes Respiratory- *asthma, emphysema, other*_____
☐No ☐Yes Gastrointestinal- *ulcers, intestinal disease, other*_____
☐No ☐Yes Blood/Lymph- *bleeding disorder, anemia, other*_____
☐No ☐Yes Neurological- *multiple sclerosis, stroke, seizures, migraines, other*_____

Please list **ALL MEDICATIONS** you are currently taking:

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Are you diabetic? ☐No ☐Yes How long? _____ Last A1C?_____

Please list any other health conditions:_____
_____

Do you use: Cigarettes/Tobacco: ☐ No ☐ Yes, Alcohol: ☐ No ☐ Yes, Other substances: ☐ No ☐ Yes

Name of family doctor: _____phone #_____

Have YOU ever been diagnosed with:

Glaucoma: ☐No ☐Yes
Dry Eye: ☐No ☐Yes
Cataracts: ☐No ☐Yes
Macular degeneration: ☐No ☐Yes
Retinal Detachment: ☐No ☐Yes
Amblyopia (lazy eye): ☐No ☐Yes

Other eye problems? explain_____

Have you had any eye operations? ☐No ☐Yes, type:_____Date_____

Have you had an eye injury? ☐No ☐Yes, kind:_____Date_____

Does anyone in your FAMILY have a history of:

☐ High blood pressure, who _____
☐ Diabetes, who _____
☐ Cataracts, who _____
☐ Macular Degeneration , who _____
☐ Retinal Detachment, who _____
☐ Glaucoma, who _____

Please review and sign below at each return visit

x_____ Date_____ x_____ Date_____
x_____ Date_____ x_____ Date_____
x_____ Date_____ x_____ Date_____
x_____ Date_____ x_____ Date_____
x_____ Date_____ x_____ Date_____

LOMAN

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Digital Retinal Imaging

Loman Eye Care is committed to providing our patients the most thorough eye health examination possible. We are pleased that we are able to perform Digital Retinal Imaging using a non mydriatic (no dilation needed) retinal camera that can aid the doctors in early detection of ocular disease & abnormalities.

If you are over 12 years of age OR have a history or family history of high blood pressure, diabetes, glaucoma or macular degeneration the doctors urge you to take advantage of this technology.

The cost is only $35.00 (Screenings are not covered by insurance)

Please indicate below:

_____ **Yes**, I want to receive the Digital Retinal Imaging at each comprehensive eye examination.

_____ **No**, I do not want to receive the Digital Retinal Imaging and acknowledge that this painless and non- invasive test is the best way to detect and monitor subtle changes in my eye health on an on-going basis.

Should you have any questions, please feel free to consult with the doctor.

* Dilation may be required for patients with small pupils.

Patient Name:_____ **Date:**_____

Notice of Privacy Practices - Acknowledgment of Receipt

I acknowledge that I have been offered or have received a copy of Loman Eye Care's Notice of Privacy Practices.

X Signature:_____ **Date**_____

Authorization To Release Information for Insurance Filing

I authorize the release of my information to my insurance carriers, including Medicare, for information required to file or resubmit my claim. I further authorize my insurance companies to pay Loman Eye Care directly on my behalf.

I further authorize all insurance companies including Medicare Supplement to provide any information to Loman Eye Care that is required to resubmit any denied or incorrectly paid insurance claims. This authorization remains in effect until withdrawn by me.

X Signature:_____ **Date**_____

Authorization to Discuss Your Information with Family or Caregivers

To comply with HIPAA Federal Privacy Regulations, we must receive your written approval to discuss your case with anyone else including family, children, caregivers, etc... By authorizing this, we will be able to, without requiring your presence, discuss your case, answer questions, leave detailed messages, and contact, in the event of an emergency, the person(s) listed below. If you would like us to answer questions or discuss your case with anyone other than yourself, you must include them below. This authorization is optional and can be withdrawn at any time by you.

(Please list anyone you give permission for us to speak with and/or allow to pick up glasses/contacts etc.)

Name: _____ Relationship: _____ Ph: _____

Name: _____ Relationship: _____ Ph: _____

Name: _____ Relationship: _____ Ph: _____

Name: _____ Relationship: _____ Ph: _____

X Signature:_____ **Date**_____

LOMAN
EYE CARE

630 3rd Ave S.W.
Suite 100
Carmel, IN 46032

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

**PLEASE FAX BACK TO 317-819-0073*

PATIENT NAME: _____ **BIRTH DATE:** ___/____/____

MAIDEN OR OTHER NAME (S)_____

The information described above may be DISCLOSED/ RELEASED from the following recipients below:

Most Recent Eye Care Provider

_____
Name

_____
Address

_____
City, State **Zip**

_____
Phone or fax number

Please Send My Healthcare Information To:

Loman Eye Care
630 3rd Ave. S.W.,
Suite 100
Carmel, IN 46032
Phone - 317.844.7474
Fax - 317.819.0073

I authorize Loman Eye Care to use or disclose (as applicable) the following information (check all that apply):

☒ Last 2 Eye Exams ☐ All Eye Records
☐ Most Recent Glasses Rx
☐ Most Recent Contact Lens Rx

☐ Other (specify) _____

Please indicate date(s) of treatment: _____

Reason for the use or disclosure (as applicable) is for the purpose of:

☐ Continuing Medical Care ☐ Insurance ☐ Legal ☐ SSI Disability Appeal
☐ Research ☒ At the Request of the Patient ☐ Other Specify _____

- I understand that Loman Eye Care will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization form, except in the following situations:
  - If the medical information to be disclosed will result from treatment for research purposes, Loman Eye Care will not provide the treatment if I am unwilling to sign this authorization form.
  - If the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, Loman Eye Care will not provide the treatment if I am unwilling to sign this authorization form.
- I understand that I may revoke this authorization by sending a written request for revocation to Loman Eye Care Privacy Officer. If I revoke this authorization, Loman Eye Care will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. I understand that when Loman Eye Care discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.
- I understand that there may be a fee associated with the release of my medical information.
- I understand that this authorization will expire 12 months from the date signed unless I indicate otherwise here _____

_____ _____ _____
Signature of Patient or Authorized Representative **Date (DD/MM/YYYY)** **Relationship to Patient (e.g. Self, POA)**

Reason Patient is Unable to Sign Release: ☐ Minor ☐ Deceased ☐ Other: _____
(Please specify and provide legal paper as needed)