Luke A. Crader, O.D

NEW PATIENT HISTORY QUESTIONAIRE

GENERAL INFORMATION

Last Name: ______________________ First Name: ______________________ MI: ________

Preferred Name: ______________________ Sex: ________

Address: ______________________ City: ______________________ State:________ Zip:______________

Preferred Telephone Number(s): ____

SSN: _______ - _______ - ________ Date of Birth: _____/_______/______ Email: ______________________

Ethnicity *(Please circle)*: Hispanic or Latino
Native Hawaiian or Other Pacific Island
Not Hispanic or Latino

Race *(Please circle)*: American Indian or Alaskan Native
Asian
Black or African American
Hispanic
Native Hawaiian or Other Pacific Island
White

Preferred Language *(Please circle)*: English
Spanish

Communication Preference: Email / Telephone / Postal / Text

Occupation: ______________________ Employer/School: ______________________

Marital Status: ______________________ Spouse or Parent's Name: ______________________

MEDICAL CONDITIONS

Condition	Current	Family History
Cardiovascular	☐	☐
General/Constitutional	☐	☐
Endocrine	☐	☐
Gastrointestinal	☐	☐
Genitourinary	☐	☐
Ear/Nose/Throat	☐	☐
Hematologic/Lymphatic	☐	☐

Condition	Current	Family History
Immunologic	☐	☐
Integumentary (skin)	☐	☐
Musculoskeletal	☐	☐
Neurological	☐	☐
Psychiatric	☐	☐
Respiratory	☐	☐

Please Explain ____

MEDICATION AND MEDICAL HISTORY

Current Medication(s). Please list all including topical medications: ______________________

____

Medication Allergy Y / N Allergic to what? ______________________

Diabetes Y / N Type: ____________ Date of Diagnosis: ____________ Last A_1C: ______________

High Blood Pressure Y / N

Have you had any major operations? Y / N Type & Year: ______________________

Name of family doctor: ______________________ Date of last visit: _____/ _____ / _____

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NEW PATIENT HISTORY QUESTIONAIRE - CONTINUED

SOCIAL HISTORY

Cigarettes/tobacco Y / N Alcohol Y / N

REVIEW OF OCULAR SYSTEM

Do you see an eye surgeon? Y / N If yes, name of surgeon: ______________________ Date of last visit: _____/ _____ / ____
Have you had any eye operations? Y / N Type & Year: ____
Have you had any eye injuries? Y / N Type & Year: ____
Do you have glaucoma? Y / N Cataracts? Y / N Macular Degeneration? Y / N
Other eye problems? Y / N What type?____
Do you wear glasses? Y / N If no, are you interested in contact lenses? Y / N
Do you wear contacts? Y / N What type? ____
Date of last eye exam: _____________________________ Doctor: ________________________________

FAMILY HISTORY OF:

Glaucoma______ Macular Degeneration______ Retinal Detachment______

MISCELLANEOUS

Whom may we thank for referring you? ____

INSURANCE/PAYMENT INFORMATION

Do you have vision insurance? Y / N Name of your vision insurance: ___________________________________

Do you have medical insurance? Y / N Name of your medical insurance: __________________________________

FINANCIAL DISCLAMERS

We will attempt to verify your insurance eligibility for services and/or materials before your appointment. Verification of eligibility is done as a courtesy only and is not a guarantee of payment. Please check with your plan administrator if you have any questions regarding your eligibility. Initial_______

LIABILITY

I understand Denton Optometry will bill my vision and/or health insurance. I know that I am responsible for any remaining balance after the claim is submitted. Should my insurance not cover the services that are submitted in full, I agree to pay any outstanding balance.

In cases of divorce, the individual who receives the care is responsible for all charges. We will not bill a divorced spouse for the patient's services. For minor patients, the responsible party bringing the minor patient to the clinic will be responsible for any co-pays or co-insurance at time of service. Initial_______

PRIVACY POLICY

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services, and to conduct health care operations involving our office. The Privacy Policy describes these uses and disclosures in detail.

I acknowledge that I have been offered and/or received a copy of the Privacy Policy from Denton Optometry.
Initial_______

REFRACTION FEE

The part of your evaluation that determines your prescription is called a refraction. A refraction is also done under certain circumstances for diagnostic purposes. If you have routine vision benefits such as VSP or EyeMed, your refraction is typically included with your exam benefits. Medical insurances that do not include routine vision benefits, such as Medicare, do not cover a refraction. The fee for a refraction is $35. My signature below verifies I understand the refraction fee. Initial_______

_______________________________________ ______________________
Patient/Guardian Signature Date