returning patient history questionnaire

Thank you for continuing to choose Brevier Optical for your vision care. In order to provide you with the best care possible, we ask that you update your contact info below:

Name: Mr./Mrs./Miss/Ms./Dr. ____ **Date:** ____________________
(First) (M.I.) (Last)

Have you changed your ADDRESS or EMPLOYMENT since your last visit? If so, please complete the following:

Address: ________________________________ **City:** ____________________ **State:** ________ **Zip:** ________________

Phone (h): (______)____________________ **Phone (w):** (______)____________________ **Phone (c):** (______)____________________

Occupation: ____ **Employer:** ________________________________

MEDICAL INFORMATION

Many systemic health conditions, as well as medications, can have an impact on the health of your eyes. Please complete the following information so your doctor can provide you with the most thorough care and evaluation of your eye health.

Have you had any changes in your health since your visit? If so, please describe:

____

Are you currently taking medication? □ **y** □ **n If yes, please list:** ____

____ **Do you use cigarettes/tobacco?** □ **y** □ **n**

Are you allergic to medication? □ **y** □ **n Please list:** ____

Name of primary care physician: ________________________________ **Date of last visit:** ____________________

PATIENT'S EYE HISTORY:

Are you having problems with:

_________ **dry eyes** __________ **dry contact lenses** __________ **red eyes** _________ **eye fatigue**

_________ **itchy eyes** __________ **floaters/flashes** __________ **headaches** _________ **eye strain**

Please describe any problems with your eyes or your vision for which you are seeking treatment today: ____________________

____

Are you interested in the following: □ **new glasses** □ **contact lenses** □ **vision correction surgery**

REQUIRED INSURANCE INFORMATION:

EMPLOYMENT STATUS: □ **full-time** □ **part-time** □ **not employed** □ **student, full-time** □ **student, part-time** □ **active duty, military**

IF YOUR INSURANCE POLICY IS NOT IN YOUR NAME, PLEASE PROVIDE THE FOLLOWING:

POLICYHOLDER'S NAME: ________________________________ **POLICYHOLDER'S DATE OF BIRTH:** _______/_______/________

POLICYHOLDER'S ADDRESS: □ **same as above OR fill out below:**

Address:________________________________ **City:**____________________ **State;**________ **Zip:**________________

I authorize Brevier Optical 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. 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.

Patient/guardian:____

FOR DOCTOR'S USE ONLY: This form was reviewed by ________________________________ date: ____________________