PATIENT HISTORY FORM

Patient Name: ______________________________ **SS#:** ____________________ **Date of Birth:** ___________

Primary Care Physician:______________________________ **Height:**________ **Weight:** ________

History of Latex Allergy? ☐ YES ☐ NO **Have you or any family members had an anesthesia reaction?** ☐ YES ☐ NO

Medication Allergies & Reactions: ____________________________________

REVIEW OF SYSTEMS - Do you currently have or have you recently had any of the following?					
System		**Yes/No**	**System**		**Yes/No**
Constitutional:	Fever	☐ Yes ☐ No	**Endocrine:**	Diabetes	☐ Yes ☐ No
	Weight Loss	☐ Yes ☐ No		Thyroid abnormalities	☐ Yes ☐ No
	Chills	☐ Yes ☐ No	**Neurological**:	Headache	☐ Yes ☐ No
Eyes:	Poor vision	☐ Yes ☐ No		Seizure	☐ Yes ☐ No
	Loss of vision	☐ Yes ☐ No		Stroke	☐ Yes ☐ No
	Eye pain	☐ Yes ☐ No		Paralysis	☐ Yes ☐ No
	Tearing	☐ Yes ☐ No	**Psychiatric:**	Anxiety	☐ Yes ☐ No
	Redness	☐ Yes ☐ No		Depression	☐ Yes ☐ No
	Jaw Pain	☐ Yes ☐ No		Insomnia	☐ Yes ☐ No
	Amaurosis fugax	☐ Yes ☐ No	**Integumentary/Skin:**		
	Scalp tenderness	☐ Yes ☐ No		Rash	☐ Yes ☐ No
ENT:	Stuffy nose	☐ Yes ☐ No		Changing moles	☐ Yes ☐ No
	Ear ache	☐ Yes ☐ No	**Musculoskeletal:**	Joint Pain	☐ Yes ☐ No
	cough	☐ Yes ☐ No		Stiffness	☐ Yes ☐ No
	Dry mouth	☐ Yes ☐ No		Arthritis	☐ Yes ☐ No
Respiratory:	Congestion	☐ Yes ☐ No	**Hematologic/Lymphatic:**		
	Wheezing	☐ Yes ☐ No		Bleeding	☐ Yes ☐ No
	Shortness of breath	☐ Yes ☐ No		Anemia	☐ Yes ☐ No
Cardiovascular:	Chest Pressure or Discomfort	☐ Yes ☐ No	**Allergic/Immunologic:**		
	Irregular Heartbeat/Palpitations	☐ Yes ☐ No		Allergies	☐ Yes ☐ No
Gastrointestinal:	Diarrhea	☐ Yes ☐ No		Hay fever	☐ Yes ☐ No
	Upset stomach	☐ Yes ☐ No		Hives	☐ Yes ☐ No
	Constipation	☐ Yes ☐ No			

Please list all Prescribed and Over-The-Counter Medications, including vitamins and supplements, you are currently taking:

Name of Prescription/Medication

Have you ever taken any of the following medications? If Yes, please check box

☐ **Cardura** ☐ **Finasteride** ☐ **Hytrin** ☐ **Uroxatral** ☐ **Flomax** ☐ **Proscar** ☐ **Jalyn**

Ocular History

Do you currently have, or have you ever had:	Yes/No	Eye	Diagnosis	Current Treatment/ Previous Surgery	When?
Eye disease	☐ Yes ☐ No				
History of double vision	☐ Yes ☐ No				
Eye Injury	☐ Yes ☐ No				
Glares and Halos	☐ Yes ☐ No				

Medical History

Do you now, or have you ever had:	Yes/No	Current Treatment/ Previous Surgery	When?
Diabetes (Type)	☐ Yes ☐ No		
Heart Disease	☐ Yes ☐ No		
Pacemaker / Defibrillator ☐ Yes ☐ No			
High Blood Pressure	☐ Yes ☐ No		
High Cholesterol	☐ Yes ☐ No		
Kidney Failure (Dialysis ☐ Yes ☐ No **)**	☐ Yes ☐ No		
Liver Disease	☐ Yes ☐ No		
Stroke	☐ Yes ☐ No		
Anemia	☐ Yes ☐ No		
Thyroid Disease:	☐ Yes ☐ No		
☐ **Overactive** ☐ **Underactive**			
Cancer or Tumor (Type)	☐ Yes ☐ No		
Females: ☐ **Pregnant** ☐ **Nursing**	☐ Yes ☐ No		
Do you wear contacts? Yes ☐ **No** ☐		**Do you wear glasses? Yes** ☐ **No** ☐	
Are you interested in Obagi? Yes ☐ **No** ☐		**Are you interested in Pelleve? Yes** ☐ **No** ☐	

Please list surgeries performed in the last 5 years:

Past Surgeries

FAMILY HISTORY: **Relationship**

☐ Yes ☐ No Blindness ______________
☐ Yes ☐ No Cancer ______________
☐ Yes ☐ No Cataracts ______________
☐ Yes ☐ No Diabetes ______________
☐ Yes ☐ No Glaucoma ______________
☐ Yes ☐ No Heart Disease ______________
☐ Yes ☐ No Hypertension ______________
☐ Yes ☐ No Macular Degeneration______________
☐ Yes ☐ No Retinal Detachment ______________
☐ Yes ☐ No Other eye/medical problems (Please Specify)____

SOCIAL HISTORY:

Use of Tobacco: ☐ Current ☐ Former ☐ Never
Amount: ________________________
Alcohol: ☐ Yes ☐ No
Amount: ________________________
Drugs: ☐ Yes ☐ No

Patient's Signature:____ Date:__________________________

Physician's Signature:____ Date:__________________________

Reviewed/Updated Date: _____________ Interval Changes ☐ Yes ☐ No MD Signature: ______________________________

PATIENT REGISTRATION FORM

PATIENT INFORMATION Today's Date ____________________________

Patient Name ____
Last First Middle

Responsible Party:_____________________________ Responsible Party DOB:_________________ Relation:_____________________

Address ____ P.O. Box ____

City _______________________________________ State ________ Zip ________ Email_________________________________

Home Phone ( ) _________________ Work Phone ( ) ____________________ Cell ( ) ________________________

Date of Birth _________________________ Age _______ Sex: M / F Drivers License # ___________________________

Language _______________________ Race ________________ Ethnicity ______________ SS#___________________________

Primary Care Physician ____

Employment Status: Full Time / Part Time Marital Status: Single / Married / Divorced / Widowed/Other

Employer Name ________________________________ Address _____________________________ Phone ___________________

Spouse's Name __________________________________ DOB ______________ SS # ____________________________________

Spouse's Employer ______________________________ Address __________________________ Phone ______________________

CONTACT INFORMATION:

In addition to myself, I designate the following individual(s) as my personal representative/emergency contact and grant associates of Logan Eye Institute permission to disclose (written or verbal) my protected health information to the individuals(s) named below.

____

Name of representative Relationship to patient

____

Name of representative Relationship to patient

- Do we have permission to leave appointment information on your answering machine or with family members? YES / NO
- Do we have permission to leave test results or surgery information on your answering machine or with family members? YES / NO

☐ I choose not to designate any other person as my personal representative.

I understand that I may revoke this authorization by written notice at any time.

INSURANCE INFORMATION **Must bring insurance card(s), we will take a copy at the front desk.**

Primary Insurance Company: ______________________________ Name of Policy Holder: ____________________________

Policy Holder's Date of Birth: ______________________________ Employer: ______________________________________

ID Number: ______________________________________ Group Number: ______________________________________

Secondary Insurance Company: ____________________________ Name of Policy Holder: ___________________________

Policy Holder's Date of Birth: ______________________________ ID Number: _____________________________________

Vision Insurance: ☐ VSP ☐ EyeMed ☐ None

HOW DID YOU HEAR ABOUT US?

Did a physician refer you? ☐ YES ☐ NO If yes, physician's name ____

☐ Newspaper ☐ Phonebook ☐ Cache Valley Guide ☐ Insurance ☐ Radio

☐ Hometown Values ☐ Movie Theater ☐ Logan Eye Institute.com ☐ Aggie Games

☐ Friend/family ____________________________________ ☐ Existing Patient

May we use your name in thanking this person? YES No

I certify that the above information is correct to the best of my knowledge:

____

Signature of Responsible Party

Logan Eye Institute Financial Policy

This is an agreement between Logan Eye Institute, as a creditor, and the Patient/debtor named on this form. In this agreement the words “you,” “your,” and “yours” mean the Patient/ Debtor. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “we,” “us,” and “our” refer to Logan Eye Institute.

By executing this agreement, you are agreeing to pay for all services that are received.

Refractions: Refraction is the process of determining the eye’s refractive error or need for corrective spectacles or contact lenses. It is an essential part of an eye examination, but is not a covered service by Medicare or most insurance’s. If it is not a covered benefit through your insurance, you will be billed a $30 refraction fee.

Insurance: Logan Eye Institute provides services to you, not your insurance company. Because of this fact, you are responsible for payment of any bill incurred in this office. As a courtesy to you, we will bill your primary and secondary insurance company. If we have not received payment from your insurance within 60 days of service, you will be responsible for paying your balance in full. You are responsible for all deductibles and charges not covered by Insurance. Please understand that as a third party, we cannot become involved in a prolonged insurance negotiation. That is your responsibility. Please contact your insurance company to inquire if we are a participating provider. All required co-payments must be made at the time of service. We accept cash, personal check, and most major credit cards. If you have medical insurance but are unable to provide a copy of your insurance card, you will need to pay for your exam on the day of service. A day of service discount will be applied.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show each date of service, a description of the services rendered, the charges, any payments made by you or your insurance, and your current balance.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Divorce: In the case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible of the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent’s responsibility to collect from the other parent.

Self-Pay: You are responsible for the full amount of the exam. A day of service discount will be available, only if you pay on the day of service. Otherwise you will be responsible for the full amount of the exam and will not receive the day of service discount.

Returned checks: There is a fee (currently $25) for any checks returned by the bank.

Liabilities: In the event that payment in full for charges incurred was not made, patient and the undersigned, if other than the patient, each jointly and severally agree to pay interest at the rate of 18% annually on all past due balances from the original due date, plus court cost and reasonable attorneys’ fees, with or without suite, incurred in collecting any past due balance, and a collection fee if my account is assigned to a collection agency. I authorize the release of financial identifiable information concerning my account (including charges billed, payments made, and interest charges assessed, etc.) to the physician’s collection agency or collection attorney should collection procedures as described become necessary.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions listed in this agreement and the financial policy will be in full force and effect.

I certify that I have accurately filled out the patient and insurance information form. I grant my permission to Logan Eye Institute and their assignee to telephone me at home or at my workplace to discuss matters relating to the Financial Policy. I certify that I have read and understand the Financial Policy and I hereby agree to abide by the conditions outlined therein.

Signature of Responsible Party:______________________________ **Date:**______________

Acknowledgement: Receipt of Logan Eye Institute’s Notice of Privacy Practices: I acknowledge that I received the Notice of Privacy Practices from Logan Eye Institute.

Patient’s name (please print):______________________________

Responsible Party’s Name (if not the patient):______________________________

Signature of Responsible Party:______________________________ **Date:**______________