Eye Level Inc.

Medical History Questionnaire

Completion required at each patient appointment

Please complete all questions:

Last Name: ______________________________ First Name:_____________________ MI:_____ Birth Date:_________________ Gender:____

Address:______________________________________ Apt #:______ City:___________________ State:_________ Zip Code:_______________

Email:____ Cell #:______________________ Daytime Phone #:__________________________

Marital Status: S____ M____ D____ W____ Emergency Contact #:______________________ Relationship:__________________

SSN:________-_____-________ Employer:___________________ Title:___________________ Date of Last Eye Exam:_________ Dilated Y/N

Personal Medical Information

Certain medical conditions are more prominent in certain ethnicities. Glaucoma is more prevalent in people of African descent, Asians, and Hispanics.

For medical reasons, we ask you to circle your ethnic background(s).

Asian/Pacific Islander Black/African Descent White Hispanic/Latinx Native American

What is your general health? ____

Do you have any problems in any of the following systems?

1. Gastrointestinal
2. Ear / Nose / Throat
3. Cardiovascular
4. Respiratory
5. Nervous System
6. Genitourinary
7. Eyes
8. Musculoskeletal
9. Integumentary (skin)
10. Psychological
11. Endocrine
12. Blood / Lymph
13. Immunologic
14. Other

Please explain if yes (list item number)

Item #______: ____ Item #______: ____

Item #______: ____ Item #______: ____

Diabetes Y/N Type:______________________ Date of Diagnosis:____________________

Non-Medication Allergies Y/N Allergic to:__________________________________ Reaction(s):__________________________

Medication Allergies Y/N Medication(s):______________________________ Reaction(s):__________________________

Current Medication(s):____

Surgical Operations? Y/N Type(s) / Year:____

Cigarettes/Tobacco: Y/N Former:______ years Packs per day:_____ Alcohol Use: Y/N Drinks per week:_____ Drinks per day:____

Other Substances (recreational) Y/N Type:______________________ Frequency per week:__________________

Name of family doctor:____ Phone:_____________________

Date of last visit:______________ Date of last tetanus shot:______________ Unsure

Personal Eye Information

Have you had any eye operations? Y/N Describe:____

Have you had any eye injuries? Y/N Describe:____

Do you have any of the following: Glaucoma Macular Degeneration Cataracts Dry Eyes Blurred Vision Blurred Night Vision

Do you see a specialist for any of the above conditions? Y/N Name/Location of Specialist:____

Do you wear glasses Y/N Contacts Y/N Type:_________________________________

Family History

High Blood Pressure Y/N Relationship(s):___________________________ Cataracts Y/N Relationship(s):____________________________

Retinal Detachment Y/N Relationship(s):___________________________ Diabetes Y/N Relationship(s):____________________________

Macular Degeneration Y/N Relationship(s):___________________________ Glaucoma Y/N Relationship(s):____________________________

Who may we thank for referring you? ___________________________________

Please continue to the other side of this form.

Please initial your acknowledgement of each section and sign at the bottom.

I, ____, understand that I am seeing (circle one): Dr. Alan Karikomi Dr. Maggie Bak
(Please print your name)

With / without:

Vision Insurance (circle those that apply): VSP EyeMed Self-Pay

Medical Insurance (circle those that apply): Aetna Blue Cross Blue Shield Cigna United Healthcare Medicare
Other (please state insurance plan name)_________________________ **Initial here:_______**

Credit Card Payment Information

I understand that if my medical insurance and/or vision care plan cannot be verified before seeing the doctor, I will be financially responsible for payment of all charges incurred for services received from the doctor's office at the time of service. In case of additional, non-billable charges, I authorize Eye Level to charge the following credit card:

Card Type (circle one): MasterCard Visa Discover AmEx Cardholder Name:_____________________________________ This is an HSA/FSA
Card#:____ Expiration Date:_____________ Billing Zip Code_________ **Initial here:_______**

Consent to Procedures: iWellness

___ I consent to the Glaucoma and Macular Degeneration detection package
___ I do not consent to the Glaucoma and Macular Degeneration detection package **Initial here:_______**

HIPAA Compliance

I acknowledge that I am aware of Dr. Alan Karikomi's Notice of Privacy Practices and will be given a copy upon request. **Initial here:_______**

Missed Appointment Policy

Our goal is to provide quality healthcare to all of our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please call our office as soon as you know you will not be able to attend your appointment.

Appointment Cancellation:

If a cancellation is necessary, we require that you call at least 2 business days in advance. Appointments are in high demand and your advanced notice will allow another patient access to that appointment time.

Late Cancellations/No-Shows:

A cancellation is considered late when the appointment is canceled less than 2 business days before the appointed time. A no-show is when a patient misses an appointment without canceling. In either case, the patient will be charged a $50 missed appointment fee.

Initial here:_______

Patient Responsibility Statement

I acknowledge that I have read and fully understand the terms and conditions stated in this form.

____ Date:_______________________
Patient Signature

____ Date:_______________________
Parent/Guardian Signature