Patient History Questionnaire

Name_____ _____ Sex_____ Today's date_____

Address_____ City_____ State_____ Zip_____

Primary Phone_____ Cell / Alternate Phone_____

Date of Birth_____ Social Security Number_____ Employer_____

E-Mail Address _____

Primary Vision Insurance_____ ID# _____ Group # _____

Name of Insurance Holder _____ Insured's Date of Birth_____

Primary Medical Insurance_____ ID# _____ Group # _____

Name of Insurance Holder _____ Insured's Date of Birth_____

Please list **ALL** medications you currently take and what you take them for. ***Include over-the-counter medications and herbal supplements***.

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Ocular	**Yes**	**No**
Amblyopia/Lazy Eye	( )	( )
Blurred Vision	( )	( )
Corneal Ulcer	( )	( )
Detached Retina	( )	( )
Dry Eyes	( )	( )
Eye Injury/Surgery	( )	( )
Flashes	( )	( )
Floaters	( )	( )
Glaucoma	( )	( )
Macular Degeneration	( )	( )

Cardiovascular	**Yes**	**No**
High Cholesterol	( )	( )
Heart Disease	( )	( )
Hypertension	( )	( )
Stroke	( )	( )
Vascular Disease	( )	( )

Constitutional	**Yes**	**No**
Cancer	( )	( )
Developmental Disability	( )	( )
Trauma/Blood Loss	( )	( )

Hematological	**Yes**	**No**
Anemia	( )	( )
Leukemia	( )	( )

Gastrointestinal	**Yes**	**No**
Colitis	( )	( )
Crohn's	( )	( )

Musculoskeletal	**Yes**	**No**
Ankylosing Spondylitis	( )	( )
Fibromyalgia	( )	( )
Muscular Dystrophy	( )	( )
Osteoarthritis	( )	( )

Neurological	**Yes**	**No**
Cerebral Palsy	( )	( )
Epilepsy	( )	( )
Multiple Sclerosis	( )	( )
Tumor	( )	( )
Headaches	( )	( )

Immunologic	**Yes**	**No**
AIDS or HIV	( )	( )
Lupus	( )	( )
Neurofibromatosis	( )	( )
Rheumatoid Arthritis	( )	( )

Psychiatric	**Yes**	**No**
ADHD	( )	( )
Depression	( )	( )
Schizophrenia	( )	( )

Allergies (please list)

Environmental

Drug

What Happens _____

Respiratory	**Yes**	**No**
Asthma	( )	( )
Bronchitis	( )	( )
COPD	( )	( )
Emphysema	( )	( )

Endocrine	**Yes**	**No**
Hormonal Dysfunction	( )	( )
Insulin Dependent Diabetes	( )	( )
Non-Insulin Dependent Diabetes	( )	( )
Thyroid Problem	( )	( )

Ear/Nose/Throat/Mouth	**Yes**	**No**
Cold Sores	( )	( )
Hearing Loss	( )	( )
Upper Respiratory Infection	( )	( )

Skin	**Yes**	**No**
Eczema	( )	( )
Psoriasis	( )	( )
Rosacea	( )	( )

Alcohol Use ( ) ( )

How long?_____ How much?_____

Tobacco Use ( ) ( )

How long?_____ How much?_____

Primary Care Physician: _____ PCP phone number: _____

Additional Information? _____

Family History	**Yes**	**No**	**Who**
Retinal Detachment	( )	( )	_____
Cataracts	( )	( )	_____
Blindness	( )	( )	_____
Crossed Eyes	( )	( )	_____
Glaucoma	( )	( )	_____
Macular Degeneration	( )	( )	_____
Stroke	( )	( )	_____

	Yes	**No**	**Who**
Diabetes	( )	( )	_____
High Blood Pressure	( )	( )	_____
Cancer	( )	( )	_____
Heart Attack/Disease	( )	( )	_____
Thyroid Disease	( )	( )	_____
Lupus	( )	( )	_____
Other	( )	( )	_____

Hudson Optometric Policy Page

HIPAA Privacy

Acknowledgement of Receipt of
Notice of Privacy Practices

I _____have been presented with the Notice of Privacy Policy of Hudson Optometric Centre and have been offered a copy of such policy to keep for my records.

Please check one

_____ I hereby acknowledge that I have been provided with a copy of the policy**.**

-or-

_____ I hereby refuse to acknowledge receipt of the policy. I understand that even though I may refuse to sign this acknowledgement the provider may still provide treatment to me.

Insurance Policy

Attention: We do our best to answer your insurance questions. However, it is ultimately the patient's responsibility to know their benefits before receiving services or materials. All insurance quotes are an estimate only and are subject to change pending insurance response. **Insurance quotes are not a guarantee of payment**. We are happy to bill your insurance for you, but if your insurance does not pay for any portion of our services and/or product then you, the patient, are responsible for the balance.

Non-Cancellation Policy

To expedite your order, we will start your spectacles immediately. Therefore, cancellations on spectacles are not permitted. **Because lenses are custom crafted and cut, patients may not switch frames after their order has been started.** For the above reasons, cash refunds are not available. Sales are FINAL on frame only purchases

Warranties and Guarantees Policy

Frames: **Hudson Optometric will repair or replace (at our discretion) broken, damaged or defective frames ONE time within 1 year of date of purchase.** This warranty DOES NOT cover loss. Damage caused by misuse or improper handling, including gluing of frames will **void** the warranty. We must have all parts of the frame for return to the manufacturer. Missing parts will also **void** the warranty. Hudson Optometric cannot be held responsible in the event that your frame becomes discontinued by the manufacturer during the warranty period and the replacement parts are no longer available.

Lenses: **Hudson Optometric will replace scratched or broken polycarbonate, scratch coated plastic, or anti-reflective lenses ONE time within 1 year from date of purchase.** Warranty DOES NOT cover loss or change in prescription. GLASS lenses and plastic lenses not scratch coated are not warranted**. I understand that I assume all responsibility for any problematic occurrences that may arise from purchasing a lens material or frame style that the Doctor or Optician has advised against**. I further understand that neither Hudson Optometric Centre nor its lens laboratories can be held financially responsible for any of the above mentioned occurrences

Patient's own frame: **I understand that in using my own frame, I assume all responsibility for breakage or damage of the frame during the process of fabricating new lenses**. I further understand the neither Hudson Optometric nor their lens laboratories can be held financially responsible for my frame, if breakage or damage does occur.

Any Rx changes must be done within 30 days of pickup to avoid product or office charges.

Contact Lens Policy

I _____**understand** the benefits and complications of wearing contact lenses.
(Patient's Name)

As a contact lens wearer I understand I am not to sleep in contact lenses and the importance to adhere to the replacement schedule as stated by the Doctors of Hudson Optometric Centre. I also understand the importance of proper lens care and handling. I agree to follow the recommended wearing and replacement schedule and to keep all appointments recommended by my doctor.

I agree to follow Dr. Martin/Corpora's advice for safe contact lens wear as indicated on the form in my record. I will notify Dr. Martin/Corpora immediately if any eye or vision problems occur. If I am unable to reach Dr. Martin/Corpora, I will call another eye doctor immediately, or go directly to an urgent/emergency facility.

I understand the **contact lens fee includes** the contact lens exam and the follow-up appointments (up to 3 visits with-in a 3 month period) following the initial contact lens exam. Any contact lens appointment beyond the courtesy visits will be charged based on the complexity level as determined by the Doctor. Furthermore, any contact lens change, as to type of contact lens or fitting of a new contact lens type may incur additional fees-indicated by Dr. Martin/Corpora (even if within the 3 month time period).

Please note: FTC regulations now specifically states that contact lens prescription expire in one year from exam date. Therefore, a yearly contact lens exam will be required to keep contact lens prescription valid.

I have read and understand the above policies _____ date_____