Montgomery Vision Care
... of course!

Patient Information Form & Health History

DATE: _____

Patient Name: _____
Patient Nickname: _____
Patient Date of Birth:_____/_____/_____
Patient Address: _____
_____
Patient Phone: _____

Insurance Information

Please complete the information as it reads on your Medical Insurance Card. There is a separate section for Vision Insurance below.

****If Patient is under Parent/ Guardian/ Spouse's Insurance, please complete the following information with the Subscriber's Information.***

Medical Insurance Carrier:

- ❑ Aetna
- ❑ Anthem/ Blue Cross Blue Shield
- ❑ CHAMPUS/ TriCare
- ❑ Cigna
- ❑ Humana
- ❑ Medical Mutual of OH
- ❑ Ohio Healthspan
- ❑ Medicare
- ❑ RR Medicare
- ❑ Secure Horizons (Through UHC)
- ❑ UMR
- ❑ United Health Care
- ❑ NONE/ Self- Pay

Montgomery Vision Care
... of course!

Medical Insurance Subscriber's Name: (as it reads on the Insurance- do not use nicknames)
_____
Medical Insurance Subscriber's Date Of Birth: _____/_____/_____
Medical Insurance Subscriber's Last 4 Digits Social Security: __ __ __ __
MEDICARE PATIENTS: Social Security Number: ____- _____-_____ (Required)
Medical Insurance Subscriber's Address: _____
_____
Medical Insurance Subscriber's Phone: _____
Medical Insurance Subscriber's Employer: _____
Medical Insurance Member ID#: _____
Medical Insurance Group ID#: _____

Vision Insurance Carrier:

- ❏ AVESIS
- ❏ Eyemed
- ❏ VCP- Comp Benefits
- ❏ VSP
- ❏ Spectera
- ❏ VBA (Vision Benefits of America)
- ❏ NONE/ Self Pay

Vision Insurance Subscriber's Name: (as it reads on the Insurance- do not use nicknames)
_____
Vision Insurance Subscriber's Date Of Birth: _____/_____/_____
Vision Insurance Subscriber's Last 4 Digits Social Security: __ __ __ __
Vision Insurance Subscriber's Address: _____
_____
Vision Insurance Subscriber's Phone: _____
Vision Insurance Subscriber's Employer: _____
Vision Insurance Member ID#: _____
Vision Insurance Group ID#: _____

PLEASE CONTINUE ON TO NEXT PAGE TO COMPLETE MEDICAL/ VISION HISTORY
This portion of the paperwork saves considerable time in the office.

Montgomery Vision Care
... of course!

Health & Vision History Information:

EYE Conditions:

Have you ever been diagnosed with any of the following:

- ❑ Cataract
- ❑ Age-Related Macular Degeneration
- ❑ Glaucoma
- ❑ Diabetes
- ❑ Diabetic Retinopathy
- ❑ Dry Eye
- ❑ Eye Infection, Inflammation, or allergy
- ❑ Floaters and/ or flashes of light
- ❑ Iritis or Uveitis
- ❑ Retina defects or Degeneration
- ❑ OTHER: _____

EYE Concerns:

Are you having any of the following eye concerns?

- ❑ Redness
- ❑ Burning
- ❑ Itching
- ❑ Tearing
- ❑ Discharge
- ❑ OTHER: _____

VISION Concerns:

Are you having any of the following Vision Concerns:

- ❑ Blurred Vision
- ❑ Eyestrain
- ❑ Eye Pain
- ❑ Severe sensitivity to light
- ❑ Headache
- ❑ Poor night vision
- ❑ Bothersome night glare
- ❑ Double vision
- ❑ Total loss of vision
- ❑ OTHER: _____

Montgomery Vision Care
... of course!

Medical History

Review of Systems:

Constitution:
- ❑ Negative
- ❑ Developmental Disabilities
- ❑ Cancer
- ❑ Fatigue Syndrome
- ❑ Other: _____

ENT:
- ❑ Negative
- ❑ Hearing Loss
- ❑ Sinusitis
- ❑ Dry Mouth
- ❑ Laryngitis
- ❑ Other: _____

Neurological:
- ❑ Negative
- ❑ Multiple Sclerosis
- ❑ Epilepsy
- ❑ Cerebral Palsy
- ❑ Tumor
- ❑ Stroke/CVA
- ❑ Migraine
- ❑ Autism Spectrum Disorder
- ❑ Other: _____

Psychiatric:
- ❑ Negative
- ❑ Depression
- ❑ Attention Deficit
- ❑ Anxiety Disorder
- ❑ Bipolar Disorder
- ❑ Other: _____

Montgomery Vision Care
... of course!

Cardiovascular:

- ❑ Negative
- ❑ Hypertension (High Blood Pressure)
- ❑ Stroke/ CVA
- ❑ Heart Disease
- ❑ Vascular Disease
- ❑ Congestive Heart Failure
- ❑ Other: _____

Respiratory:

- ❑ Negative
- ❑ Cigarette Smoker
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Chronic Obstruction
- ❑ Sleep Apnea
- ❑ Other: _____

Gastrointestinal:

- ❑ Negative
- ❑ Crohn's Disease
- ❑ Colitis
- ❑ Ulcer
- ❑ Acid Reflux
- ❑ Celiac Disease
- ❑ Other: _____

Genitourinary:

- ❑ Negative
- ❑ Kidney Disease
- ❑ Prostate Disease/Cancer
- ❑ Benign Prostate Hypertrophy
- ❑ Herpes
- ❑ Chlamydia
- ❑ Pregnant
- ❑ Nursing
- ❑ Other: _____

Montgomery Vision Care
... of course!

Musculoskeletal:

- ❑ Negative
- ❑ Arthritis
- ❑ Osteoarthritis
- ❑ Fibromyalgia
- ❑ Muscular Dystrophy
- ❑ Ankylosing Spondylitis
- ❑ Osteoporosis
- ❑ Gout
- ❑ Other: _____

Integumentary:

- ❑ Negative
- ❑ Eczema
- ❑ Rosacea
- ❑ Psoriasis
- ❑ Herpes Simplex/ Cold sores
- ❑ Herpes Zoster/ Shingles
- ❑ Other: _____

Endocrine:

- ❑ Negative
- ❑ Type 2 Diabetes Mellitus
- ❑ Type 1 Diabetes Mellitus
- ❑ Thyroid Disfunction
- ❑ Hormonal Disfunction
- ❑ Other: _____

Hematologic/ Lymphatic:

- ❑ Negative
- ❑ Anemia
- ❑ Large Volume Blood Loss
- ❑ Ulcer
- ❑ Hypercholesterolemia
- ❑ Other: _____

Montgomery Vision Care
...of course!

Allergic/ Immune:

- ❏ Negative
- ❏ Drug Allergies
- ❏ Environmental Allergies
- ❏ Rheumatoid Arthritis
- ❏ Lupus
- ❏ Sjogren's Syndrome
- ❏ Other: _____

Medications:
Please list any medications you take:

Medication Allergies:

Environmental & Food Allergies:

Montgomery Vision Care
... of course!

Ocular (Vision) History

Check any of the conditions you have had:

- ❑ Negative
- ❑ Glaucoma
- ❑ Glaucoma Suspect
- ❑ Cataract
- ❑ Age-Related Macular Degeneration
- ❑ Surgery
- ❑ Patching
- ❑ Inflammatory Disorder
- ❑ Strabismus
- ❑ Amblyopia
- ❑ Retinal Degeneration
- ❑ Retinal Hole
- ❑ Retinal Detachment
- ❑ Keratoconus
- ❑ Injury
- ❑ Dry Eye
- ❑ Nystagmus
- ❑ OTHER: _____

Social History

Drinking Alcohol:

- ❑ Yes
- ❑ No
- ❑ Amount: _____

Tobacco Use:

- ❑ Yes
- ❑ No

  Status:
  - ❑ Current everyday smoker
  - ❑ Current some day smoker
  - ❑ Former smoker
  - ❑ Never smoker

Montgomery Vision Care
... of course!

Family Medical History

- ❑ Cancer Type: _____ Father/ Mother/ Brother/ Sister
- ❑ Hypertension (High Blood Pressure) Father/ Mother/ Brother/ Sister
- ❑ Heart Disease Father/ Mother/ Brother/ Sister
- ❑ Stroke Father/ Mother/ Brother/ Sister
- ❑ Vascular Disease Father/ Mother/ Brother/ Sister
- ❑ Diabetes Mellitus Type: _____ Father/ Mother/ Brother/ Sister
- ❑ Thyroid Disease: _____ Father/ Mother/ Brother/ Sister
- ❑ OTHER: _____ Father/ Mother/ Brother/ Sister

Family Ocular History

- ❑ Negative Father/ Mother/ Brother/ Sister
- ❑ Glaucoma/ Glaucoma Suspect Father/ Mother/ Brother/ Sister
- ❑ Cataract Father/ Mother/ Brother/ Sister
- ❑ Age-Related Macular Degeneration Father/ Mother/ Brother/ Sister
- ❑ Patching Father/ Mother/ Brother/ Sister
- ❑ Inflammatory Disorder Father/ Mother/ Brother/ Sister
- ❑ Strabismus Father/ Mother/ Brother/ Sister
- ❑ Amblyopia Father/ Mother/ Brother/ Sister
- ❑ Retinal Degeneration Father/ Mother/ Brother/ Sister
- ❑ Retinal Hole Father/ Mother/ Brother/ Sister
- ❑ Retinal Detachment Father/ Mother/ Brother/ Sister
- ❑ Keratoconus Father/ Mother/ Brother/ Sister
- ❑ Dry Eye Father/ Mother/ Brother/ Sister
- ❑ Nystagmus Father/ Mother/ Brother/ Sister
- ❑ OTHER: _____

Montgomery Vision Care
... of course!

Patient Acknowledgment & Authorization

I acknowledge that the above information is accurate and I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize Montgomery Vision Care to secure the payment of benefits through my insurance provider. I authorize the use of this signature on all Insurance submissions.

_____ _____/_____/_____

SIGNATURE DATE