COVID-19 Questionnaire

Due to recent events and concerns, we are taking precautionary measures such as sanitizing each area after patient use, ensuring use of face masks, and maintaining the 6 feet distance between patients to ensure the safety of our patients and ourselves.

Here are some steps you can take to protect ourselves and others:

- Wash your hands often with soap and water for at least 20 seconds, especially before eating
- Avoid close contact with people who are sick
- Avoid touching your eyes, nose, and mouth
- Stay home when you are sick
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash
- Clean and disinfect frequently touched objects and surfaces
- Wear a face mask or cover and gloves if available

Please read the information below and check the boxes off that apply.

[ ] I have been in close contact with someone who is ill

[ ] I am currently feeling ill

[ ] None of the above

I _____ acknowledge that I have read the information above, my responses are true, and I will do my part in taking precautionary measures to ensure everyone's safety. We are sorry for the inconvenience that this may cause. We are wishing you and your loved ones the best of health.

_____ _____

Signature **Date**

HUNSTVILLE FAMILY VISION

Welcome to our office!

PATIENT INFORMATION

Last Name:_____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ Email:_____

Date Of Birth: ___/___/___ Employer: _____

Social Security #: _____

Medical Insurance: _____ Typo: [ ] HMO [ ] PPO unfortunately we're not taking HMO right now, and we are unable to make exceptions.

Vision Insurance: _____

Primary Insurance Holder's Name and DOB: _____

Last 4 Number of SSN _____

Reason for visit: _____

Secondary reason: _____

Have you worn contact lenses before? Yes / No

ADDITIONAL TESTING (These services are normally covered under medical)

[ ] **Dilation ($25 Charge**): It is recommended if you have not been dilated in the previous two years, you have any medical condition that can affect your vision, you are over 40, or you have a family history of glaucoma.

[ ] **GDX Screening**: **($30 Charge):** In glaucoma testing, the traditional pressure check does not always lead to proper diagnosis. This screening is a comfortable procedure that can test if any structural damage has been done to the eye.

Contact lens patients only, I understand that I am solely responsible for the care and well being of the contact lenses prescribed today. Contacts are to be disposed of properly according to your prescription. I understand that I am to be held accountable for any misuse of contacts and will exercise proper preventive measures. State laws require first time wearers to schedule a follow up appointment with the doctor to ensure proper use of the contacts. **X**_____

OFFICE USE ONLY

PP/INS/VISION _____/_____ Reason for visit: GLS CL MEDICAL COPAY_____

NCT: ___/____ HEIGHT: _____ WEIGHT: _____ AGE: _____

TEMP: _____ OLD RX OD: _____ OS: _____ ADD: _____ AGE RX: _____

MEDICAL HISTORY

	Yes	No			Yes	No
Do you have diabetes?	☐	☐	If yes, how many years? _____	Using medication?	☐	☐
Do you have high blood pressure?	☐	☐	If yes, how many years? _____	Using medication?	☐	☐
Do you have cholesterol problems?	☐	☐	If yes, how many years? _____	Using medication?	☐	☐
Allergic to any medications?	☐	☐	Which ones? _____			

Please LIST START DATE and all medications you are taking, including OTC, homeopathic, birth control or home remedies:

_____

_____

Please list and date all major injuries, surgeries, and hospitalizations you have had:

_____

_____

REVIEW OF SYMPTOMS

Do you currently have any problems with:

	Yes	No
Constitutional (fever, weight loss, appetite)	☐	☐
Integumentary (skin conditions/disorders)	☐	☐
Neurological (headaches, migraines, seizures)	☐	☐
Endocrine (thyroid, diabetes)	☐	☐
Ear, Nose, Throat (allergies, cough, dry mouth)	☐	☐
Respiratory (asthma, emphysema, bronchitis)	☐	☐
Vascular (hypertension, stroke, heart pain)	☐	☐
Gastrointestinal (diarrhea, constipation)	☐	☐
Genitourinary (kidney, bladder, genitals)	☐	☐
Bones/Joints (rheumatoid arthritis, muscle pain)	☐	☐
Lymphatic/Hematologic	☐	☐
Allergic/Immunolgical	☐	☐
Psychiatric (depression, anxiety)	☐	☐

OCULAR REVIEW OF SYMPTOMS

Do you currently have any problems with:

	Yes	No	Which eye? Right	Which eye? Left
Sudden Vision Loss	☐	☐	☐	☐
Blurred vision	☐	☐	☐	☐
Loss of side vision	☐	☐	☐	☐
Double vision	☐	☐	☐	☐
Floaters	☐	☐	☐	☐
Flashes of light	☐	☐	☐	☐
Mucous discharge	☐	☐	☐	☐
Redness	☐	☐	☐	☐
Gritty feeling/dryness	☐	☐	☐	☐
Itching/burning	☐	☐	☐	☐
Tearing/watery	☐	☐	☐	☐
Glare/light sensitivity	☐	☐	☐	☐
Eye pain/discomfort	☐	☐	☐	☐
Haloes at night	☐	☐	☐	☐

Are you sensitive to (check all that apply):

☐ Heaters ☐ Blowers ☐ Animals ☐ Smog ☐ Contact solution

☐ Dust ☐ Pollen ☐ Cigarettes ☐ Contacts ☐ Air conditioning

FAMILY HISTORY

	Yes	No	Relationship to you (parent, sibling, etc.):
Blindness	☐	☐	
Cataracts	☐	☐	
Glaucoma	☐	☐	
Macular Degeneration	☐	☐	
Retinal disease	☐	☐	
Arthritis	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
High Blood Pressure	☐	☐	
Heart disease	☐	☐	
Kidney disease	☐	☐	
Thyroid disease	☐	☐	

How did you hear about us? _____

PERSONAL HISTORY

This is stirctly confidential and you may discuss it with the doctor

Family doctor's name: _____

Family doctor's phone number: _____

Last medical exam: _____

Last eye exam: _____

Ethnicity: _____

	Yes	No
Do you drive?	☐	☐
Do you have visual difficulty driving?	☐	☐
Do you use tobacco products?	☐	☐
Do you use alcohol products?	☐	☐
Do you use iliccit drugs?	☐	☐
Have you been exposed to any infectious diseases?	☐	☐
Females, check if you are pregnant or nursing	☐	☐

HUNTSVILLE FAMILY VISION

Medical Insurance Waiver

Huntsville Family Vision is committed to caring for our patient's eye health. When many patients think about getting an eye exam, they are thinking about a prescription for glasses or contacts. Many do not think of it as a medical health exam. As a courtesy, we are happy to file with your insurance company, provided that we are in their network. HFV is legally bound to follow healthcare guidelines regarding billing your insurance. Medical eye exams are filed under your Medical insurance while a routine vision exam is filed under your Vision insurance. Medical Eye Exam can include diagnosis and plan for Glaucoma, Cataracts, Diabetic Retinopathy, Macular Degeneration, Retinal Detachment, as well as others not corrected by glasses or contacts. **Ex: A typical routine eye exam for glasses (covered by vision ins) may be subject to going medical (medical/health ins) if something such as an eye infection is present.**

PRIVACY PRACTICE:

The laws require that Infinite Vision, PLLC make an effort to inform you of your rights related to your personal healthy information. The US Department of Health and Human Service issued the privacy rule implement the requirement of Health Insurance Portability and Accountability Act of 1996. The privacy rule standards address the use and disclosure of protected health information. A major goal of the privacy rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide, protect, and promote high quality health care and well-being.

FINANCIAL AGREEMENT:

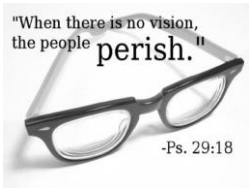
I, _____ understand that due to Walmart Policies, vision products (materials such as frames or supply of contacts) are NOT sold in our office; they may be purchased in vision centers of the patients choice. ALL PAYMENTS MADE ARE FEES FOR PROFESSIONAL SERVICES AND NON-REFUNDABLE. In the case the patient is not happy with their prescription, he/she can return for 2 visits within 60 days of the initial visit for a glasses check. In the case of a contact lens fitting, the patient is responsible for contact lens care and can return for 2 visits within 30 days of the initial visit both at not extra cost (as long as there is no underlying medical condition).

I,_____ accept full financial responsibility for my account.

I,_____ understand Huntsville Family Vision (Infinite Vision, PLLC) is accepting my insurance as a courtesy to me as the patient. I grant them permission to release my information to the proper entities to file such claims. I agree that I will furnish correct and active information so the claim can be filed in a timely manner as required by my insurance company. I understand that by not providing the appropriate information (change of policy, employment or insurance company), my claims may be improperly processed or not processed at all, leaving me responsible for the balance on my account. Unfortunately, we are not able to bill third-party insurances at this time.

_____ _____

Patient or Guardian/ Representative signature Date



Katherine Hyde, OD
License # 6079TG
Therapeutic Optometrist
Optometric Glaucoma Specialist

Huntsville Family Vision, I-45 South, Suite A, Huntsville, Texas 77340
Phone: 936-295-CARE (2273) Fax: 936-295-2297

AUTHORIZATION TO RELEASE IDENTIFYING HEALTH INFORMATION

Patient Name: _____ **Date of Birth :** _____

Previous Name
(if applicable): _____

I hereby request and authorize INFINITE VISION, PLLC to release health information identifying me (including, if applicable information about substance abuse, mental health conditions, and HIV infection or AIDS), the above named, to the following people/facilities:

Name: _____

_____

_____

_____

Example: If there is anyone you would like to pick up your prescription, please list their names above.

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

☐ All healthcare information

It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you may revoke it at any time by contacting in writing, FAX, or email, the Privacy Official noted in the Notice of Privacy Practices.

When your health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

Patient Signature: _____ **Date Signed**: _____

If you are signing as a personal representative of the patient, please indicate your relationship.

_____ _____

Representative Relationship to Patient

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED