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745 South Highway 65, Ste. 70
Lincoln, California 95648

TODAY'S DATE _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

PLEASE SHOW YOUR INSURANCE CARD(S) TO THE FRONT DESK

NAME: _____ AGE: _____

ADDRESS: _____

Street City State Zip Code

SOCIAL SECURITY#: _____ PERSONAL PHYSICIAN: _____

HOME PHONE: _____ BUSINESS PHONE _____

SEX: M ___ F ___ DATE OF BIRTH: ___/___/___ SINGLE ___ MARRIED ___ MINOR ___

EMPLOYER: _____ OCCUPATION: _____

SPOUSE'S NAME: _____ EMPLOYER: _____

PERSON RESPONSIBLE FOR BILL: (If Other Than Above)

NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ HOME PHONE: _____

SOCIAL SECURITY# _____ DATE OF BIRTH: _____

EMPLOYER: _____ WORK PHONE: _____

NEAREST RELATIVE TO NOTIFY IN AN EMERGENCY:

NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ HOME PHONE: _____

FINANCIAL POLICY

Payment for services is expected at the time of your visit. We will bill your insurance as a **courtesy** if you provide a copy of your card and any special claim forms. It is **your responsibility** to ensure that we are covered under your plan. You, by law, are required to pay any and all deductibles and/or co-payments at the time of each visit. **Any authorization from your insurance is not guarantee of payment.** If your insurance company does not pay in 60 days, we will require you to pay the balance due. If your insurance company pays past the 60 days, we will refund you any overages. Returned checks and balances older than 90 days may be subject to additional collection fees and interest charges. If you have any questions regarding this policy please feel free to contact us at (916) 434-6225.

I HAVE READ THIS AGREEMENT

Patient/Guardian Signature: _____ DATE: _____

SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions. I authorize release of information to all of my insurance companies. I understand that I am responsible for my bill. I authorize payment direct to my doctor and I permit a copy of this authorization to be used in place of the original.

NAME: _____

SIGNATURE: _____

Medical History Questionnaire

Name: _____ Today's Date: _____

Last Eye Exam: _____ Last Medical Exam: _____

Medical History

Do you have any allergies to medications? ___No ___Yes If yes, explain: _____

Please attach list of any medications you take including oral contraceptives, aspirin, over the counter medications and home remedies. _____

List all major injuries, surgeries and or hospitalizations you've had: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injuries: _____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer. ___ Yes I would prefer to discuss my social history information directly with my doctor.

Do you drive?: ___No ___ Yes

If yes, do you have visual difficulty when you drive? ___No ___ Yes

If yes, describe: _____

Do you use tobacco products? ___No ___ Yes If yes, type/amount/how long: _____

Do you drink alcohol? ___ No ___ Yes If yes, type/amount/how long: _____

Do you use illegal drugs? ___No ___Yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ___Gonorrhea ___ Hepatitis ___ HIV ___ Syphilis

Family History

DISEASE/CONDITION	YES	NO	?	RELATIONSHIP TO YOU
Blindness	_____	_____	_____	_____
Cataract	_____	_____	_____	_____
Crossed Eyes	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____
Macular Degeneration	_____	_____	_____	_____
Retinal Detachment/Disease	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Kidney	_____	_____	_____	_____
Disease	_____	_____	_____	_____
Lupus	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____
Other _____	_____	_____	_____	_____

Please turn this form over and complete side 2

Review of Systems: Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?	SYSTEM	NO	YES	?
CONSTITUTIONAL				EARS, NOSE, MOUTH, THROAT			
Fever, Weight loss/gain	___	___	___	Allergies/Hay Fever	___	___	___
INTEGUMENTARY (skin)	___	___	___	Sinus Congestion	___	___	___
NEUROLOGICAL				Runny Nose	___	___	___
Headaches	___	___	___	Post-Nasal Drip	___	___	___
Migraines	___	___	___	Chronic Cough	___	___	___
Seizures	___	___	___	Dry Throat/Mouth	___	___	___
EYES				RESPIRATORY			
Loss of Vision	___	___	___	Asthma	___	___	___
Blurred Vision	___	___	___	Chronic Bronchitis	___	___	___
Distorted Vision/Halos	___	___	___	Emphysema	___	___	___
Loss of Side Vision	___	___	___	VASCULAR/CARDIOVASCULAR			
Double Vision	___	___	___	Diabetes	___	___	___
Dryness	___	___	___	Heart Pain	___	___	___
Mucous Discharge	___	___	___	High Blood Pressure	___	___	___
Redness	___	___	___	Vascular Disease	___	___	___
Sandy/gritty feeling	___	___	___	GASTROINTESTINAL			
Itching	___	___	___	Diarrhea	___	___	___
Burning	___	___	___	Constipation	___	___	___
Foreign Body Sensation	___	___	___	GENITOURINARY			
Excess Tearing/Watering	___	___	___	Genitals/Kidney/Bladder	___	___	___
Glare/Light Sensitive	___	___	___	BONES/JOINTS/MUSCLES			
Eye pain/Soreness	___	___	___	Rheumatoid Arthritis	___	___	___
Chronic Eye/lid Infection	___	___	___	Muscle Pain	___	___	___
Sties/Chalazion	___	___	___	Joint Pain	___	___	___
Flashes/Floaters	___	___	___	LYMPHATIC/HEMTOLOGIC			
Tired Eyes	___	___	___	Anemia	___	___	___
ENDOCRINE				Bleeding Problems	___	___	___
Thyroid/Other Glands	___	___	___	ALLERGIC/IMMUNOLOGIC	___	___	___
				PSYCHIATRIC	___	___	___

If you answered YES to any of the above or have a condition not listed, please explain and list medications: _____

Doctor Signature: _____ Date: _____