Patient History Questionnaire

Last Name______________________________ First Name_______________ MI____

Address______________________________ City____________________ Zip_____

Work/Cell Phone___________________ Home Phone______________DOB__/__/___

Occupation___________________________ Employer__________________________

Medical Information

How is your general health?___________________ Blurred vision/when? _______________

Do you have problems with any of these systems?

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/bones	Yes/No	Immune	Yes/No
Respiratory	Yes/No	Skin	Yes/No	Headaches	Yes/No
High Blood Pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain any yes answers____

Diabetes Yes/No___ Type______ How Long?______ Allergies to Medications?_____________

Current Medications ____

Other Health Concerns? ________________________ Eye Surgeries? ___________________

Family Dr.__________________ Phone #___________ Date of Last Tetanus Shot ___________

Family History - (self, grandparents, mother, father, siblings)

High Blood Pressure	Yes/No	Diabetes	Yes/No	Glaucoma	Yes/No
Macular Degeneration	Yes/No	Cataracts	Yes/No	Retinal Detach	Yes/No

Personal Eye Information

Any eye conditions or problems? (dry eye or allergies)________________________________

Any eye surgeries or injuries?______________________ Do you wear glasses?____________

Contact lenses?____ type and brand of lenses______________ Date of last exam/dilation? _____

Do you have current prescription in your glasses?_______ Date eyewear last replaced? _________

Reviewed by:

INSURANCE INFORMATION

Patient Name ________________________________ D.O.B.___/___/____Sex: M F

Address__________________________________SS#______________________

__________________________________Home Phone________________

Employer ________________________________Work/Cell #________________

VISION INSURANCE

Name of Insured______________________________ D.O.B.___/___/___

SS# of insured____-____-_____Home Phone# ____________Work/Cell#___________

Name of Insurance Co.______________________

ID#________________________________Group#_________________________

Employer of insured ______________________________Phone #_______________

Address____

MEDICAL INSURANCE

Name of Insured ______________________________D.O.B.___/___/___

SS# of insured____-____-_____Home Phone# ____________Work/Cell#___________

Name of Insurance Co. ________________________

ID#________________________________Group#_________________________

Employer of Insured _______________________________Phone#_______________

Address____

EMERGENCY CONTACT

Name ________________________________Phone# _________________________

Relation to patient____________________________

Whom may we thank for referring you to our office? ____________________________

I request that payment of authorized benefits be made on my behalf to **Dr. Jon E. Noll** for any services furnished me. I authorize any holder of medical information to release said information as needed to determine the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

____ ________________

Signature of patient Date

I have been notified of Dr. Jon E. Noll's Notice of Privacy Practices.

____ ________________

Signature of Patient Date

JEN/pks'09

Financial Policy of Dr. Jon Noll's Practice

Thank you for choosing Dr. Jon Noll for your care. We are providing the following information to help you understand our insurance and billing policies. Your insurance policy is a contract between you and your insurance company. We will submit claims to your insurance carrier for care you received if you have given us the required information. Please be aware that some or all of the services provided to you may be considered "non-covered" services or exclusions according to your insurance policy. Therefore, you are responsible for payment of these services.

Certain insurance carriers require referrals. It is the patient's responsibility to obtain this from their Primary Care Physician (PCP) before their visit. If a referral is not obtained, the patient is responsible for payment of services. If you are covered by a non-participating plan, we will request payment at the time of service for all office visits. We accept assignment for most major insurance companies. However, you may be responsible for payment of the office visits, co-pays, deductibles, coinsurance or non-covered services at the time of service.

Timely payments from insurance companies can be a problem for medical practices. Therefore, our office follows these billing procedures:

1 We file an insurance claim within 5 days of your visit

2 We will submit a second claim in 30 days if we do not receive a response

3 After 45 days of no response from the carrier, you will receive a statement. After 60 days, the balance due for materials and services rendered will be the patients' responsibility.

If you have a financial problem, please contact our office to discuss a payment plan. We require monthly payments. We accept cash, checks, MasterCard and Visa. In the event a personal check is returned "NSF" from your bank, your account will be charged an additional $35.00.

Minor patients (under 18 years of age)

The parent/ guardian/adult accompanying the patient are responsible for payment. If both parents have health insurance please check your policy to see if the birthday rule or gender rule applies to determine the primary carrier.

If your account is past due, you will be required to pay the balance before treatment is resumed.

I understand and agree to this policy

Signature of patient or responsible party______________________________ Date________

Print name of patient________________________ Birth-date_____________ JEN/pks'09

Initial ________________ Date______________

Initial ________________ Date_____________

Initial ________________ Date ____________

Initial ________________ Date _____________

Initial ________________ Date_____________

Initial ________________ Date______________

Initial ________________ Date _____________

Initial ________________ Date______________

Initial ________________ Date______________

Initial ________________ Date ______________