

## 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 \_\_\_\_\_

## 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 \_\_\_\_\_

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