

Dr. Robert Zoellner and Associates

APPT: \_\_\_\_\_ WI: \_\_\_\_\_

NP / PP - GL / CL

Welcome To Our Office

Welcome to Dr. Robert Zoellner and Associates. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Mr.  Miss  Mrs.  Ms.  Male  Female

\_\_\_\_\_  
First Name MI Last Name Preferred Name

\_\_\_\_\_  
Street Address City State Zip

\_\_\_\_\_  
Social Security Number Date of Birth Home Phone - Include Area Code Day Phone

\_\_\_\_\_  
Email Address Guardian Person Responsible for Account

How were you referred to our office?

Phone Book  School  Advertisement  Patient Current Occupation : \_\_\_\_\_  
 Insurance Listing  Drive by  Other  Doctor

VISION INSURANCE INFORMATION

M  F

\_\_\_\_\_  
Insured's First Name MI Insured's Last Name

\_\_\_\_\_  
Insureds Address City State Zip

\_\_\_\_\_  
Insured's Social Security # Insured's Place of Employment

\_\_\_\_\_  
Name of Vision Insurance Company City State Zip

\_\_\_\_\_  
Insured's Identification Number Group Number Insured's Date of Birth

**Patient Relationship to Insured**  Self  Spouse  Child  Other  
**Patient Status**  Single  Married  Other  
 Full Time Student  Part Time Student  Employed

PATIENT HISTORY AND INFORMATION

What is the main reason for today's exam ? \_\_\_\_\_ When was your last exam ? \_\_\_\_\_

Past Eye Surgeries: \_\_\_\_\_

Current Medications: \_\_\_\_\_

HEALTH HISTORY

Current Eye Drops: \_\_\_\_\_

Medicines that cause reactions or sensitivities: \_\_\_\_\_

Specific Allergies: \_\_\_\_\_

Name \_\_\_\_\_

### EYE HISTORY

Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Dryness	<input type="radio"/> Yes <input type="radio"/> No	Strabismus (Crossed Eyes)	<input type="radio"/> Yes <input type="radio"/> No
Cataract	<input type="radio"/> Yes <input type="radio"/> No	Excess Tearing/Watering	<input type="radio"/> Yes <input type="radio"/> No	Blurred Vision Distance	<input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No	Eye Pain or Soreness	<input type="radio"/> Yes <input type="radio"/> No	Blurred Vision Near	<input type="radio"/> Yes <input type="radio"/> No
Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No	Foreign Body Sensation	<input type="radio"/> Yes <input type="radio"/> No	Distorted Vision (halos)	<input type="radio"/> Yes <input type="radio"/> No
Color Blindness	<input type="radio"/> Yes <input type="radio"/> No	Infection of Eye or Lid	<input type="radio"/> Yes <input type="radio"/> No	Double Vision	<input type="radio"/> Yes <input type="radio"/> No
Headaches	<input type="radio"/> Yes <input type="radio"/> No	Itching	<input type="radio"/> Yes <input type="radio"/> No	Floaters or Flashes	<input type="radio"/> Yes <input type="radio"/> No
Glare/Light Sensitivity	<input type="radio"/> Yes <input type="radio"/> No	Mucous Discharge	<input type="radio"/> Yes <input type="radio"/> No	Fluctuating Vision	<input type="radio"/> Yes <input type="radio"/> No
Tired Eyes	<input type="radio"/> Yes <input type="radio"/> No	Drooping Eyelid	<input type="radio"/> Yes <input type="radio"/> No	Loss of Vision	<input type="radio"/> Yes <input type="radio"/> No
Amblyopia (Lazy Eye)	<input type="radio"/> Yes <input type="radio"/> No	Redness	<input type="radio"/> Yes <input type="radio"/> No	Loss of Side Vision	<input type="radio"/> Yes <input type="radio"/> No
Burning	<input type="radio"/> Yes <input type="radio"/> No	Sandy or Gritty Feeling	<input type="radio"/> Yes <input type="radio"/> No	Flashes of Light	<input type="radio"/> Yes <input type="radio"/> No

### GENERAL HEALTH CONDITION

Fever	<input type="radio"/> Yes <input type="radio"/> No	Respiratory (Asthma)	<input type="radio"/> Yes <input type="radio"/> No	Anxiety or Depression	<input type="radio"/> Yes <input type="radio"/> No
Weight Loss	<input type="radio"/> Yes <input type="radio"/> No	Gastrointestinal	<input type="radio"/> Yes <input type="radio"/> No	Thyroid, Diabetes	<input type="radio"/> Yes <input type="radio"/> No
Other Symptoms	<input type="radio"/> Yes <input type="radio"/> No	Kidney	<input type="radio"/> Yes <input type="radio"/> No	Blood/Lymph	<input type="radio"/> Yes <input type="radio"/> No
Ears, Nose, Throat	<input type="radio"/> Yes <input type="radio"/> No	Muscles, Bones, Joints	<input type="radio"/> Yes <input type="radio"/> No	Allergic	<input type="radio"/> Yes <input type="radio"/> No
Cardiovascular (high blood pressure etc.)	<input type="radio"/> Yes <input type="radio"/> No	Skin	<input type="radio"/> Yes <input type="radio"/> No	Are you?	<input type="checkbox"/> Pregnant <input type="checkbox"/> Nursing
		Neurological (Multiple Sclerosis)	<input type="radio"/> Yes <input type="radio"/> No		

### FAMILY HISTORY

Amblyopia (Lazy Eye)	<input type="radio"/> Yes <input type="radio"/> No	Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Blindness	<input type="radio"/> Yes <input type="radio"/> No	Strabismus (Eye Turn)	<input type="radio"/> Yes <input type="radio"/> No	Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No
Cataract(s)	<input type="radio"/> Yes <input type="radio"/> No	Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Lupus	<input type="radio"/> Yes <input type="radio"/> No
Color Blindness	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No	Heart Disease	<input type="radio"/> Yes <input type="radio"/> No	Others	<input type="radio"/> Yes <input type="radio"/> No

### MEDICAL HISTORY QUESTIONNAIRE

#### SOCIAL HISTORY

Do you drink alcohol? If yes, how much/often :  No  Occasional  1 Per Day  2-3/day  4+/day

Do you smoke? If yes, how much/often :  No  Occasional  1/2 pack/day  1 pack/day  1+ pack

Method of Tobacco Intake :  Smoking  Chewing

Any History of tobacco, alcohol or substance abuse? \_\_\_\_\_

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# Patient Consent Form

I understand that under the Health Insurance Portability Accountability Act of 1966 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

\*Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly or indirectly.

\*Obtain payment from third-party payers.

\*Conduct normal healthcare operations such as quality assessment and physician certifications.

I have been informed by your office of your *Notice of Privacy Practices* containing a more completed description of the uses of my health information. I have been given the right to review such *Notice of Privacy Practices* from time to time and know that I may contact this organization at any time to obtain a current copy of *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

**If patient cannot sign or is a minor, please sign below and indicate relationship to patient**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_