Mann Eye Institute

Medical History Questionnaire

Name: ________________________________ Date of Birth: ________________ Date: ________________________

Height: ________ Weight: ________ Do you wear contacts or glasses? O Yes O No Type: ________________________

List any **medications** you currently take **with dosage** (Rx or over the counter):

____

____

____

Do you have allergies to medications? O Yes O No If yes, please list below.

____

____

____

Pharmacy Phone ______________________________

Have you or any of your family members been diagnosed with any of the following conditions?

Condition:	You	Family	Details
Glaucoma			
Macular Degeneration			
Cataracts			
Retinal Detachment			
Keratoconus			
Dry Eyes			

List any surgeries: ____

____

List any medical conditions (Diabetes, High Blood Pressure, Thyroid, HIV, AIDs, cancer, etc.):

____

____

Are you pregnant or nursing? ____

Do you drink alcohol: O Yes O No How often? ______________________________________

Do you smoke: O Yes O No How often? ______________________________________

Check the boxes that apply:

Constitutional	Cardiovascular	Metabolic/Endocrine	Integumentary
O Fatigue O Fever O Night Sweats	O Chest Pressure or Discomfort O Irregular Heartbeat Palpitations	O Cold Intolerance O Heat Intolerance O Excessive Thirst (polydipsia) O Excessive Hunger (polyphagia) O Frequent Urination (polyuria)	O Skin Rash
HEENT	**Gastrointestinal**	**Neurological**	**Musculoskeletal**
O Hearing Loss	O Constipation O Diarrhea O Vomiting	O Dizziness O Abnormal Walking (gait disturbance) O Headache	O Joint Pain (arthralgias) O Joint Swelling O Muscle Weakness
Respiratory	**Genitourinary**	**Psychiatric**	**Hema/Lymph**
O Cough O Wheezing	O Painful Urination (dysuria) O Blood in Urine (hematuria)	O Emotional Changes	O Bleeding O Bruising

Immunologic	Chief Complaint: Please check any of these you are experiencing			
O Environmental Allergies O Food Allergies	O Blurry Vision O Decreased Vision O Foreign Body O Trouble Reading O Other, please explain:	O Floaters O Trouble Driving O Bloodshot O Halos	O Glare O Redness O Headache/ Flashes	O Dryness O Pain O Burning O Failed Vision Screening

Signature on File, Assignment of Benefits, Financial Agreement HIPAA Notice

Name:_________________________________ **Date:**______________________

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to **The Mann Eye Institute** for services furnished me by **Doctor(s).** I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS 1500 form, my signature authorizes releasing the information to the Insurer or agency shown. **The Mann Eye Institute** accepts the charge determination of the Medicare carrier as the full charge, and **I am responsible for the deductible, coinsurance and non-covered services.** Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance Is Indicated in Item 9 of the HCFA1500 form, my signature authorizes release of the Information to the insurer or agency shown. I request that payment of authorized secondary Insurance benefits be made on my behalf to **The Mann Eye Institute**, If possible or otherwise to me.

3. **OTHER INSURANCE:** I authorize payment of my medical and surgical Insurance benefits to **The Mann Eye Institute.** I understand I am financially responsible for any charges whether or not paid by said Insurance. If co-payments and/or deductibles are designated by my Insurance company or health plan, I agree to pay them to **The Mann Eye Institute.** I authorize **The Mann Eye Institute** to release any Information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

4. **NON-COVERED SERVICES:** I understand that **The Mann Eye Institute's** contract with health care services plans (i.e., HMOs, PPOs) relates only to items and services which are "covered" by the health care service plans. Accordingly, **I accept full financial responsibility for all Items or services, which are determined by the health care service plans not to be covered, including the refraction fee.** I agree to cooperate with **The Mann Eye Institute** to obtain necessary health care service plan authorizations.

5. **FINANCIAL AGREEMENT: I agree that in return for the services provided to me by The Mann Eye Institute, I will pay my account at the time service is rendered.** If my account is sent to an agency for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that If my account Is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance are hereby assigned to **The Mann Eye Institute**. If co-payments and/or deductibles are designated by my Insurance company or health plan, I agree to pay them to **The Mann Eye Institute**. However, I understand that I am primarily responsible for the payment of my bill.

6. **HIPAA NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received the Notice of Privacy Practices Issued by **The Mann Eye Institute** that was effective April 14, 2003. I agree to allow electronic communication as defined in security practices effective March 26th^th, 2013.

Please direct complaints to: Texas Department of State Health Services
110 West 49th Street, Austin, TX. 78756 Phone: 1.888.973.0022

I have read and understand these instructions and have a copy for my review.

Signature____

Mann Eye Institute

Demographics

Date: ______________________________ Date of Birth: ______________________________

Patient's Name: ____
Last First MI

Address: ____
Street City State Zip

Patient SSN# __________________ Sex: ☐M ☐F E-mail: ______________________________

Preferred Phone: __________________________ Alternate Phone: ____________________________

Policy Holder Information:

What Insurance Will We Be Filing? ____

Policy Holder Name: ____________________________________ DOB: __________________

SSN# ________________________ Relationship to Patient: ____________________________

Occupation: ______________________________ Employer: ________________________________

Certain races or ethnicities have an increased risk for different conditions so we ask you please complete the following: ETHNICITY: ☐ Latino ☐ Non-Latino ☐Unknown/Decline

Language Preference: ____

Check the applicable RACE below:

☐ American Indian / Alaskan Native
☐ Asian
☐ Unknown / Decline
☐ Native Hawaiian / Pacific Islander
☐ Black / African American
☐ White
☐ Other Race

How did you hear about us? (Please Be Specific) ____

Referring Eye Doctor/Physician: ______________________Phone # _________________Last Exam: _________

In case of emergency, please contact ________________________ Phone # ________________________

I hereby consent to a health examination, related diagnostic procedures and treatments provided by Mann Eye Institute. I also authorize the use of my photographs or data collections taken to document my ocular condition for routine care or use in research and professional publication. Photo static copies of this authorization will be considered valid as the original.

By signing below, I authorize the following people to receive information regarding my treatment or care. (If you wish to add names later on, please confirm this in writing, or contact our staff.)

Spouse: ____________________________________ ______ yes ______ no

Parent: ____________________________________ ______ yes ______ no

Other: _____________________________________ ______ yes ______ no

Signature: ________________________________ Printed Name: ______________________________

(Please circle one) Patient Legal Guardian