Hockemeyer Family Eye Care

1010 Boulder Ridge Trail

New Haven, IN 46774

Date:____/_____/________

ALL AREAS MUST BE COMPLETED:

Name: ____**DOB:** ____/_____/_________

Age: _____ **Sex:** M F

Address: ____

City: ______________________ **State:** ___________ **Zip:** _______ **SS#** ______________________

Home phone: ___________________ **Work:** _________________ **Cell:** ______________________

E-Mail Address: ______________________________________ **Last Eye Exam:** _________________

Marital Status: Single Married Widowed Divorced Separated

Employer: ______________________________ **Spouse's Name**: ______________________________

Employed: Full-time Part-time Not at all **Student:** Full-time Part-time

Preferred Language: English Spanish Declined to Specify French Japanese

Race: American Indian or Alaska Native Asian Black or African American Declined to Specify
Native Hawaiian or Other Pacific Islander White

Ethnicity: Declined to Specify Hispanic or Latino Native Hawaiian/Other Pacific Islander
Not Hispanic or Latino

Communication Preference: Email Mail Telephone Cell Phone

☐ Text messaging is OK

If you are a minor or not otherwise legally responsible for your own fees, please supply the following information.

Name of person financially responsible: ____

Their DOB: _______________ **Their SS#:** _____________________ **Relationship:** ________________

NOTICE OF PAYMENT POLICY

All professional fees, including exam and any additional testing recommended by the doctor, are due and payable the day they are provided. If glasses or contact lenses are included in your fees, 50% is required when ordering and the balance is due at dispensing.

If your fees are covered by an insurance company for which we are a participating provider, any applicable deductibles, co-payments, and non-covered services and/or materials are due and payable on the date of your examination.

I understand that any fees incurred are my responsibility, regardless of any insurance benefits. I acknowledge that they are to be paid as stated in the above payment policy. Any collections and/or legal fees are also my responsibility. **Initial here** _______________

____ __________________________

Patient/Financially Responsible Signature Date

Medical History Questionnaire

Name:_________________________Date:______________Family Medical Doctor:________________________

List any medications you are taking (prescription and over the counter including aspirin, vitamins, etc.):

____

____

Please let us know who to thank for referring you if this is your first visit:______________________________

Do you have any allergies to medications?_____Yes______No If YES, list the medications:

____

Review of Systems

Do you CURRENTLY have any problems in the following area? YOU MUST CHECK YES OR NO.

System	YES	NO	Explanation of problem
GENERAL/CONSTITUTIONAL (Fever, weight loss, other)			
EAR, NOSE AND THROAT (sinus, ear infection, chronic cough, dry mouth)			
CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (asthma, emphysema, TB, etc.)			
GASTROINTESTINAL (stomach ulcers, intestinal disease, etc.)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
SKELETAL (osteoporosis, arthritis)			
NEUROLOGICAL/PSYCHIATRIC (anxiety, depression, persistent headaches)			
BLOOD (cholesterol anemia, lupus, etc.)			

PAST EYE HISTORY AND RELATED SYSTEMATIC CONDITIONS

Have you EVER been diagnosed with the following conditions?

IF YES, INDICATE WHEN DIAGNOSED AND TREATED.

Condition	YES	NO	Date diagnosed and description of treatment
MACULAR DEGENERATION			
GLAUCOMA			
CATARACTS			
EYE INJURY			
EYE SURGERIES			
DIABETES			
HIGH BLOOD PRESSURE			
CANCER			
STROKE			
ARTHRITIS			

FAMILY HISTORY

M=Mother F=Father S=Sibling MGM=Maternal Grandmother MGF=Maternal Grandfather

PGM=Paternal Grandmother PGF=Paternal Grandfather

Disease	YES	NO	Relationship to patient
BLINDNESS			
MACULAR DEGENERATION			
GLAUCOMA			
CATARACTS			
DIABETES			
CANCER			

Current Occupation:______________________________Do you smoke? No____Yes____Packs Per Day____