Springfield Family Eyecare
2 Summer St. Springfield, VT 05156
p: 802-885-4190 **f:** 802-885-4173

Patient History Questionnaire

To be updated at each visit

Last Name _____ First Name _____ MI_____

Address _____ Town _____ ZIP _____

Phone _____ Email _____

Date of Birth _____ Last 4 of SSN# _____ Employer _____

Emergency Contact _____ Phone _____

Date and location of last eye exam _____

Primary Care Provider _____

Medical History

Do you have any problems with the following? *(Y – YES N – NO)*

Eyes Y/N Diabetes Y/N Cardiovascular Y/N Respiratory Y/N Skin Y/N Blood/Lymph Y/N

Endocrine (glands) Y/N Musculoskeletal Y/N Ear/Nose/Throat Y/N Stomach/Intestines Y/N

Genitourinary Y/N Immune System Y/N Nervous System Y/N Mental Health Y/N Headaches Y/N

Allergies Y/N Allergies to medications? Please list: _____

All current medications: _____

Other health problems: _____ Pregnant or Nursing Y/N

Any surgeries? Y/N _____ When? _____

Do you use cigarettes/tobacco/vape? Y/N Alcohol? Y/N Other substance? Y/N

Eye Information

Any eye operations? _____ Date _____ Eye Injury? _____ Date _____

Do you have: Glaucoma Y/N Macular Degeneration Y/N Cataracts Y/N Dry Eyes Y/N Blurry vision Y/N

Other eye problems? _____

Do you wear glasses? Y/N Contact lenses? Y/N Type _____

Additional information: _____

Family History

Please provide the type of relationship (M, F, GM, GF, sister, brother, etc.)

Diabetes _____ Glaucoma _____ Cataracts _____ Cancer _____

Macular degeneration _____ Retinal detachment _____High blood pressure _____

Other eye conditions? Y/N Description _____ Relationship_____

Do you have any questions regarding your eyes? _____

VISION PLANS POLICY

Springfield Family Eyecare **does not** participate in vision plans such as Eyemed, VSP, Cigna Vision, etc. To use a vision plan benefit for eyeglasses or contacts, it is the responsibility of the patient to submit reimbursement paperwork to their vision benefit provider. Reimbursement forms are available at the front desk.

I understand Springfield Family Eyecare does not participate in vision benefit plans.

_____ _____
Initial Date

REFRACTION POLICY

Refraction is an important part of your eye exam which determines the need for corrective glasses or contacts. It also provides important information about the function of your eyes and may alert your doctor to problems that are related to a decrease in visual acuity.

Refraction is not a covered service by most medical insurance plans (including Medicare). These plans consider refraction a "vision" service and not a "medical" service. **Our fee for refraction is $50**. Unless your plan automatically covers the refraction (e.g., Green Mountain Care), this fee is collected in addition to any co-pay required by your plan. You may wish to check with your insurance plan about this benefit.

I understand a $50 fee for refraction is required to receive a prescription for glasses unless my medical insurance plan covers it.

_____ _____
Initial Date

INSURANCE AUTHORIZATION

I, the undersigned, have insurance with _____
and assign directly to Springfield Family Eyecare all medical benefit payment for services rendered. I authorize release of my information to secure payment of benefits. I understand I must notify Springfield Family Eyecare of changes to my insurance before my visit to ensure proper billing. I authorize the use of this signature on all my insurance submissions.

I understand I am financially responsible for all charges not paid by insurance. I understand my co-payment and/or deductibles are due at the time of service.

_____ _____ _____
Printed name of Patient or Responsible Party Signature of Patient or Responsible Party Date