DR. TAMMY HERSCH, Optometrist
DR. ERYN CAUDILL, Optometrist

Family Optical
1420 North Ave, Suite 1, Spearfish, SD 57783
605-642-0387

Medical History Questionnaire

Name: _____ Date: _____
Last First Middle Nickname

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Email Address: _____ Work Phone: _____

Social Security #: _____ Date of Birth: _____ Age: _____

Marital Status: S M D W If student, grade in school _____

Place of Employment: _____ Occupation: _____

Primary Care Physician: _____ Pharmacy: _____

If other than above
Person responsible for bill: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ DOB: _____

Place of Employment: _____ Work Telephone Number: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian

Do you have vision insurance? ☐ Yes ☐ No Name of Insurance: _____

Do you have health insurance? ☐ Yes ☐ No Name of Insurance: _____

If you have either, please present cards to the front desk.

Insurance/Medicare Authorization

I hereby authorize Dr. Hersch or Dr. Caudill to furnish to Medicare/insurance carriers any information needed to determine benefits payable for services furnished to me. I request payment of these benefits be made to Dr. Hersch or Dr. Caudill. I understand I am responsible for any amount not covered by Medicare/Insurance.

Signature _____ Date _____

Payment is expected at the time services are rendered. No refunds will be made for services.

Reason for eye exam _____ Date of Last Eye Exam_____

How did you hear about us? _____

Are you interested in: ☐ Contacts ☐ Glasses ☐ Both

Do you have a history of...?

__ arthritis
__ allergies
__asthma
__injury to eyes
__high blood pressure
__discharge from eye
__light flashes
__floating spots
__eye surgery
__head injury
__glaucoma
__cancer/tumor
__headaches
__diabetes
__drug allergies
__skin conditions
__current smoker or tobacco user
__former smoker
__ have never been a smoker

Explanation or Other: _____

_____

Has anyone in your family had...?

	Relationship to you		Relationship to you
__ diabetes	_____	__ other eye disease	_____
__ heart disease	_____	__ blindness	_____
__ high blood pressure	_____	__ glaucoma	_____
__ other	_____		

Please list all prescription and non-prescription medications

_____

_____

_____

_____

Please list all drug allergies

_____

_____

_____

_____

Optomap

We recommend our patients include an Optomap, which can be used as part of your eye exam to take a digital scan of the back of your eye. This will help to ***evaluate the overall health of your retina*** and assist in the ***early detection of eye diseases***. It produces a 200 degree view of the retina and may take the place of dilation of the eyes. Both Dr. Hersch and Dr. Caudill believe the Optomap is an essential part of the comprehensive eye exam and prescribe it for ***patients of all ages*** during their annual exam. The screening is ***$39*** and not billable to insurance.

_____ I DO want the Optomap screening _____ I DO NOT want the Optomap screening

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I received a copy of Family Optical's Notice of privacy Practices.

Patient Name: _____ Date:_____

Signature: _____

FAMILY OPTICAL
1420 NORTH AVENUE, SUITE 1
SPEARFISH, SD 57783
605-642-0387

YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER, AND THE INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT.

ALL CHARGES ARE YOUR RESPONSIBILITY, WHETHER YOUR INSURANCE COMPANY PAYS OR NOT. NOT ALL SERVICES ARE COVERED BENEFITS IN ALL CONTRACTS. SOME INSURANCE COMPANIES ARBITRARILY SELECT CERTAIN SERVICES THEY WILL NOT COVER. PLEASE UNDERSTAND THAT OUR PATIENTS HAVE HUNDREDS OF DIFFERENT POLICIES AND IT IS IMPOSSIBLE TO KEEP ABREAST OF EVERYONE'S CHANGES AND COVERAGE. WE WILL DO OUR BEST TO ASSIST YOU.

FEES FOR SERVICES, ALONG WITH UNPAID DEDUCTIBLE AND COPAYMENTS ARE DUE AT THE TIME OF SERVICE. WE ESTIMATE THESE PAYMENTS FOR YOU WITH ALL GIVEN INFORMATION WE HAVE AVAILABLE.

I AUTHORIZE RELEASE OF ANY MEDICAL AND /OR PERSONAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS. I AUTHORIZE PAYMENT OF GOVERNMENT BENEFITS TO EITHER MYSELF OR THE PARTY WHO ACCEPTS ASSIGNMENT.

SIGNATURE: _____

PRINTED NAME: _____ **DATE:** _____

Lifestyle Questionnaire

Please tell us a little bit about yourself so that we can understand how you use your eyes and provide you with the most customized eyewear solution for you.

What hobbies/activities do you participate in?

_____

_____

Do any of these situations cause you to have eye strain? (Circle all that apply)

Car Headlights	Haze	Fluorescent lights	Sunshine
Night Driving	Traffic Lights	Digital Devices	Other: _____

What do you like about your current glasses? (Color, style, fit, etc.)

_____

_____

What don't you like about your current glasses? (Weight, thickness, glare, etc.)

_____

_____

On average, how many hours a day do you spend on your digital devices such as a tablet, computer, cell phone, gaming device?

0-4 hours 4-8 hours 8-12+ hours

Does your work or after work activities cause you to go from indoors to outdoors frequently?

Yes No

Do you currently have prescription sunglasses?

Yes No