DR. TAMMY HERSCH
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: _____

Work Phone: _____

E-mail Address: _____ Marital Status: S M D W
(optional - to receive specials/promotions)

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

Occupation: _____ If student, grade in school: _____

Place of Employment: _____

Primary Care Physician: _____

Person responsible for bill: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ 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. Tammy Hersch to furnish to Medicare/insurance carriers any information needed to determine benefits payable for services furnished me. I request payment of these benefits be made to Dr. Tammy Hersch. 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 ☐ Colored Contacts

Do you have a history of:

___ arthritis	___ high blood pressure	___ eye surgery	___ cancer/tumor	___ headaches	___ skin conditions
___ allergies	___ discharge from eye	___ head injury	___ sinus problems	___ diabetes	___ smoking or tobacco use
___ asthma	___ light flashes	___ glaucoma	___ red eyes	___ drug allergies	___ have never been a smoker
___ injury to eyes	___ floating spots				

Explanation or Other: _____

_____

Has anyone in your family had. . . ? Relationship to You

___ diabetes _____
___ heart disease _____
___ high blood pressure _____
___ glaucoma _____
___ other eye disease _____
___ blindness _____
___ other _____ _____

Please list all prescription and non-prescription medications

_____
_____
_____
_____

List Drug Allergies

_____
_____
_____
_____

VISUAL FIELDS SCREENING

This instrument can assist in early detection of many disorders, including brain tumors, glaucoma, diabetes and retinal detachments. This is optional, unless your doctor recommends this screening. We strongly recommend that all our patients receive the screening version of this exam. It is especially important for people who have:

☐ headaches	☐ a history of high blood pressure	☐ see spots or flashes of light
☐ reached the age of 35	☐ a strong eyeglass prescription	☐ circulatory problems

There is an additional charge of $30 for this service.

____ I DO want the visual field exam ____ I DO NOT want the visual field exam

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I received a copy of Dr. Tammy Hersch's Notice of Privacy Practices.

Patient Name _____

Signature _____

Date _____

Sand Creek Printing Spearfish • (605) 642-4061 • 04-05-10, Rev. 10-03-13 • Medical History Questionnaire