Dr. Gary J. Morgan
Dr. F. Kent Aide
Dr. Charles C. Assell
& Associates

ILLINOIS EYE CARE CENTER

Hoffman Estates
Palatine
Schaumburg

Medical History Interview

To comply with medical record requirements, please complete the following information

First name _____ MI____
Last name _____
Address _____
City _____ Zip_____
Home Phone _____
Work Phone_____ Cell _____
E-mail Address _____
Marital Status _____
Name of spouse _____
Responsible party if patient is a minor (under 18) _____

Today's date _____
Date of birth _____ Age_____
Male____ Female ____
Social Security # _____
Occupation _____
Employer _____
How did you hear about our office? _____
Has any member of your household had an exam here? ☐Yes ☐No
Name _____

What is your reason for today's eye exam?

_____blur at distance
_____blur at near
_____double vision
_____computer strain
_____headache
_____glaucoma
_____lazy eye
_____red eyes
_____flashes/spots
_____tears/discharge
_____eye pain/discomfort
_____itching
_____broken glasses
_____contact lenses
_____trauma

Have you had an eye injury? ☐Yes ☐No If yes, explain _____
Have you had eye surgery? ☐Yes ☐No If yes, explain _____
How old are your glasses?_____
Are you interested in Contact Lenses? ☐Yes ☐No
If you are presently wearing contacts, what type? ☐Hard ☐Soft ☐Disposable
Are you interested in Lasik surgery? ☐Yes ☐No

Medical History

Do you have, or have you ever been treated for:

_____diabetes
_____high blood pressure
_____heart disease
_____stroke
_____stomach problems
_____thyroid problems
_____arthritis/joint pain
_____kidney/urinary
_____STD
_____cancer
_____HIV
_____headache
_____breathing problems
_____depression/anxiety
_____sinus/allergy
_____skin condition
_____hearing loss

List any other medical conditions or surgeries: _____
Do you take any **medications**? ☐Yes ☐No If yes, list _____
_____
Do you have any allergies? ☐Yes ☐No If yes, explain _____
Are you now pregnant or nursing? ☐Yes ☐No
Do you smoke? ☐Yes ☐No
Do you drink alcohol? ☐Yes ☐No
Do you have a history of drug use? ☐Yes ☐No If yes, explain _____

Please list the people in your family who have the following medical problems:

_____diabetes
_____arthritis
_____glaucoma
_____blindness
_____high blood pressure
_____sickle cell disease
_____macular degeneration
_____cancer
_____heart disease
_____retinal disease
_____crossed eyes
_____other

(over)

Insurance Authorization

It is understood that the undersigned patient is eligible for benefits under this plan. Any quote of benefits is just an estimate provided to us by your insurance company. Payment will not be determined until the claim is received. Therefore, we are unable to guarantee any quote of benefits. In the event the patient is not eligible for coverage, has not met their deductible, insurance does not pay as expected, or the insurance company does not respond within 30 days of submitting the claim the patient or responsible party is ultimately responsible for any unpaid balance. There will be an additional fee of $20.00 for any claim we have to turn over to our collection agency.

Patient Signature _____ Date of Service _____

Responsible Party _____

Signature _____ Date of Service _____

Contact Lens Policy

Most insurance companies cover for a **Standard Eye Examination** only. This includes an assessment of the overall health of the eye and a prescription for glasses.

Examination for contact lenses is generally not covered by most insurance companies, and the following additional tests are necessary in order to determine a precise fit and proper contact lens prescription and to determine the eye's ability to safely wear contact lenses.

- Assessment and health of your cornea.
- Training of insertion and removal for new wearers.
- Keratometry - measures the central curve of the eye - needed to determine lens shape, size, and power.
- Slit lamp biomicroscopy - microscopic evaluation of the front of the eye to rule out any conditions that could interfere with lens wear such as infection, allergies, inflammation, or scarring.
- Tear volume & tear quality assessment.
- Examination with your present contact lenses.
- Determination of the contact lens prescription - different from the glasses prescription; the power needed in the lens to provide maximum vision.
- Contact lens design & analysis of fit - evaluation of the lens on the eye to ensure a healthy fitting relationship; specifically, proper centration and movement when blinking.

There is an additional professional fee for the contact lens evaluation and fitting. The fee varies depending on the complexity of the prescription, the type of contact lens and the services necessary for the most optimal fit.

Acknowledgement of the Above Contact Lens Policy and Fitting Fee

Patient Signature _____ Date of Service _____

Responsible Party _____

Signature _____ Date of Service _____

Acknowledgement of Receipt of Privacy Practices

I, _____ have reviewed/received a copy of Illinois Eye Care Centers Notice of Privacy Practices.

Print Name_____ Signature_____ Date_____