PATIENT HISTORY FORM

Terry R. Van Der Heyden, O.D.
4060 Tamiami Trail No. #4
Naples, FL 34103

Patient Name: _____ Date of Birth: _____

If married, name of spouse: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: Home: _____ Work: _____

Occupation: _____ Employer: _____

If Patient is a Minor, please list Parent/Guardian Name: _____

Person Responsible for this Account: _____

Insurance: _____ Name of Insured: _____ DOB: _____
ID No. _____ Group: _____

Who Referred You to Our Office? _____

Approximate Date of Your Last Eye Exam: _____

Do You Wear Glasses? Yes No Contacts? Yes No When Were They Prescribed? _____

List Any Medications You Currently Take: _____

List Any Known Allergies (including drugs or food) : _____

Have You Had Any of the Following Eye Health Problems:

Eye Injuries	Yes	No	Eye Surgery	Yes	No	Glaucoma	Yes	No
Retina Detachment	Yes	No	Crossed or Lazy Eye	Yes	No	Other Eye Diseases	Yes	No
Laser Surgery	Yes	No	Explain Any Yes Answers: _____					

Do You Have History of Any of the Following Conditions:

Previous Major Surgery	Yes	No	Stroke	Yes	No	Heart Problems	Yes	No
High Blood Pressure	Yes	No	Breathing Problems	Yes	No	Diabetes	Yes	No
Arthritis	Yes	No	Thyroid Disease	Yes	No	Cancer	Yes	No
Kidney Problems	Yes	No	Ulcers/Stomach	Yes	No	Bleeding	Yes	No
Other Major Illness	Yes	No						

Explain Any Yes Answers: _____

_____

Please turn over and fill out reverse page→

Do You Smoke? Yes No How Frequently?_____
Do You Use Alcohol? Yes No How Frequently?_____

Family History:

Have Any Close Blood Relatives Had Any of the Following?			Which Relative?
Cataracts	Yes	No	_____
Glaucoma	Yes	No	_____
Diabetes	Yes	No	_____
Macular Degeneration	Yes	No	_____
Retinal Detachment	Yes	No	_____
Blindness	Yes	No	_____
Heart Disease	Yes	No	_____
High Blood Pressure	Yes	No	_____
Crossed Eyes	Yes	No	_____
Lazy Eye	Yes	No	_____

I request that payment of authorized benefits be made either to me or on my behalf to Dr. Van Der Heyden for any services furnished. I authorize any holder of medical information about me to release to all my insurance carriers and its agents any information necessary to determine these benefits or the benefits payable for related services.

I understand that eligibility for vision services is determined at the time a claim is received by my carrier, and in the event that services are denied I will be responsible for payment.

I authorize Dr. Van Der Heyden to disclose my medical records to the physician of my choice if a referral for further treatment is necessary.

I acknowledge that I have read or received a copy of the Notice of Privacy Practices.

FOR PATIENTS WHO ARE MINORS: As guardian I give permission for my minor child to be treated by Dr. Van Der Heyden.
Guardian Signature: _____ Relationship: _____

Date:_____Patient Signature:_____

UPDATES;
REV'D BY:_____/_____DATE_____ ( )Updated ( )No Change
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