PATIENT DEMOGRAPHICS FORM

William L Yoos, OD, FIAO
2692 Bella Vista Way
Bella Vista, AR 72714-3704
479-876-2020

Date _____ **SSN:** _____

Guardian (if patient is under 18) _____

Patient's Name _____ _____
(Last) (First) (M.I) (Suffix)

Nickname or name you go by _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Preferred Contact (**please circle one; needed for insurance claims**) Text Cell Phone Work Phone Home Phone Email Mail

Birth date _____ Sex **M F**

Marital Status (**please circle one; needed for insurance claims**) Annulled Divorced Domestic Partner Interlocutory Legally Separated Married Never Married Polygamous Widowed

Is your billing address different? If so, please enter that address here:

Address _____

City _____ State _____ Zip _____

Are you (**please circle one**): Employed Full-Time Student Part-Time Student Retired?

Occupation _____

Employer/School Name _____

Emergency Contact Name & Phone Number _____

_____

Dr. Yoos Eye Care & Optical

2692 Bella Vista Way
Bella Vista, AR 72714-3704

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I hereby acknowledge that on _____
I received the Notice of Privacy Practices from Dr. Yoos Eye Care & Optical, which sets forth the ways in which my personal health information may be used or disclosed by Dr. Yoos and his staff, and outlines my rights with respect to such information.

_____

Patient's signature and date

SIGNATURE ON FILE/FINANCIAL AGREEMENT/RELEASE FORM
UPDATED 03/31/2021

The clinic expects payment in full at the time services or goods are provided. This includes co-pays, deductibles, and services/goods not covered by insurance!!

- **If you expect to use your insurance for your office visit, bring your insurance card with you to be copied and put into your file. This needs to be updated each year or whenever you change your insurance policy. Keep in mind that for vision, there are two different types of exams, medical and routine. We will need a copy of both cards to determine patient eligibility. Failure to do so may result in the charges being assigned to you, the patient. You are responsible for all co-pays, deductibles, and charges determined by your insurance company. No account filed using insurance is "Paid in full" until the clinic receives payment and the statement from your insurance company which details what they will and will not pay. Again, you are responsible for any balances that your insurance company assigns to you.**
- **If you do not have insurance, payment is due at the time of service in full.**

***If you, the patient, are the subscriber, skip this section; we will make a copy of your insurance card. You still need to sign and date at the bottom.**

***If you are not the subscriber, please complete the following section:**

Primary Subscriber's Name as Printed on Insurance Card: _____

_____

Subscriber's ID # _____ **Subscriber's DOB** _____
Address (if different from patient's) _____
City _____ **State** _____ **Zip Code** _____
Phone Number _____

All patients need to please sign below; thank you!!

I agree that in return for the services and/or goods provided by Dr. Yoos Eye Care & Optical, I will pay my account at the time services or goods are rendered. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to Dr. Yoos Eye Care & Optical. If co-payments and/or deductibles are required by my insurance company or health plan, I agree to pay them to Dr. Yoos Eye Care & Optical at the time of my visit. However, I understand that the undersigned and /or the patient are primarily responsible for the payment of my bill .

_____ _____

(Patient/Guardian's Signature if under 18) **(Date)**

DR YOOS EYE CARE & OPTICAL
2692 Bella Vista Way
Bella Vista, AR 72714-3704

Patient Name _____ **Date** _____

Patient Ocular History

	Yes	No
Glaucoma	___	___
AMD	___	___
Ret Detach	___	___
Cataract	___	___
Amb/Str	___	___
Blindness	___	___
Lazy Eye	___	___
Color Blind	___	___
Double Vision	___	___
Eye Infection	___	___
Flashers	___	___
Floaters	___	___

Other Ocular Conditions:

Eye Surgeries:

Eye Injuries:

Patient Medical History

	Yes	No	# of Years
Diabetes Type I	___	___	___
Diabetes Type II	___	___	___
__Insulin __Non-Insulin __a1C			
HTN	___	___	
Thyroid	___	___	
CVD	___	___	
Cancer	___	___	
Arthritis	___	___	
Asthma	___	___	
Emphysema	___	___	
Headaches	___	___	

Other Family Medical Conditions:

Height: ___ft ___in

Weight: ____lbs

Family Ocular History

	M	F	SIB	PGM	PGF	MGM	MGF	NO
Glaucoma	__	__	__	__	__	__	__	__
AMD	__	__	__	__	__	__	__	__
Ret Detach	__	__	__	__	__	__	__	__
Cataract	__	__	__	__	__	__	__	__
Amblyopia	__	__	__	__	__	__	__	__
Blindness	__	__	__	__	__	__	__	__

Other Family Ocular Conditions: _____

_____

_____

Family Medical History

	M	F	SIB	PGM	PGF	MGM	MGF	NO
Diabetes	__	__	__	__	__	__	__	__
HTN	__	__	__	__	__	__	__	__
Thyroid	__	__	__	__	__	__	__	__
CVD	__	__	__	__	__	__	__	__
Cancer	__	__	__	__	__	__	__	__
Other Family Medical Conditions:						FHx	UNKN	___

HTN = HIGH BLOOD PRESSURE
AMB/STR = LAZY EYE
CVD = CARDIVASCULAR DISEASE
FHx = FAMILY HISTORY
AMD = MACULAR DEGENERATON

Dr. Yoos Eye Care & Optical
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Patient Name: _____

Please complete each item; thank you!

Social History

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other Race
- ☐ Patient Declined to Specify
- ☐ White

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown
- ☐ Patient Declined to Specify

Preferred Language (please write in) _____

Smoking Status

- ☐ Current smoker
- ☐ Former smoker
- ☐ Never a smoker

*Please circle yes or no on these last items; thank you!

Alcohol Use	Yes	No
Illegal Drug Use	Yes	No
Are you pregnant?	Yes	No
Breast feeding?	Yes	No
Had flu shot?	Yes	No
Been exposed to any sexually transmitted diseases?	Yes	No

Please list all current medications, noting name and delivery method (ex: aspirin, tablet).

_____
_____
_____
_____
_____
_____
_____

Current Eye Drop Therapy _____
_____
_____

Allergies: _____
_____
_____
_____

Primary Care Physician: _____

REVIEW OF SYSTEMS

*please mark each item; thank you!

Patient Name _____ **Date**_____

SYSTEM	YES	NO	?	SYSTEM	YES	NO	?
CONSTITUTIONAL				**ENDOCRINE**			
Fever				Thyroid			
Weight loss/gain				Diabetes			
NERVOUS SYSTEM				Neck pain			
Headaches				**CONNECTIVE TISSUE**			
Migraines				Lupus			
Seizures				Auto immune disease			
EYES				Other			
Glaucoma				**EARS, NOSE, MOUTH, THROAT**			
Loss of vision				Sinus congestion			
Blurred vision				Runny nose			
Distorted vision/halos				Postnasal drip			
Double vision				Chronic cough			
Dryness				Dry throat/mouth			
Mucous discharge				**RESPIRATORY**			
Redness				Asthma			
Sandy or gritty feeling				Chronic bronchitis			
Itching				Emphysema			
Burning				**VASCULAR/CARDIOVASCULAR**			
Foreign body sensation				Chest pain			
Excess tearing/watering				Heart pain			
Glare/light sensitivity				High blood pressure			
Eye pain or soreness				Vascular disease			
Infection of eye or lid				High cholesterol			
Chalazion				**CONTINUE ON NEXT PAGE PLEASE:**			

REVIEW OF SYSTEMS

*please mark each item; thank you!

Patient Name _____ **Date**_____

EYES	YES	NO	?
Flashers/floaters in vision			
Tired eyes			
SYSTEM	**YES**	**NO**	**?**
GASTROINTESTINAL			
Diarrhea			
Constipation			
Acid reflux			
Colitis			
Stomach ulcer			
GENITOURINARY			
Genitals			
Kidney			
Bladder			
BONES/JOINTS/MUSCLES			
Rheumatoid arthritis			
Muscle/joint pain			
Swollen joints			
LYMPHATIC/HEMATOLOGIC			
Anemia			
Bleeding problems			
Blood disorders			
Lupus			

VASCULAR/CARDIOVASCULAR	YES	NO	?
CONTINUE ON NEXT PAGE PLEASE:			
SYSTEM	**YES**	**NO**	**?**
ALLERGIC/IMMUNOLOGIC			
Allergies			
Hay fever			
INTEGUMENTARY (SKIN)			
Excessive dryness			
Itching			
Rashes			
PSYCHIATRIC			
ADHD			
Anxiety			
Depression			
Special needs/concerns			