Bettendorf Eyecare Center
1875 Middle Road
Bettendorf, IA 52722

Advanced Eyecare
251 N 6th Ave
Eldridge, IA 52748

WELCOME TO OUR OFFICE

Aaron Chizek, OD **Ammie Chizek, OD** **J Conner Peters, OD**

- Please complete this questionnaire PRIOR to your appointment.
- Please bring your vision plan and health insurance cards to your appointment.
- Contact lens patients - please wear your contact lenses to your appointment. Bring your glasses and your contact lens prescription or boxes.
- We accept the following forms of payment **at time of service**: Cash, Check, Visa, Mastercard, Discover, American Express and Care Credit.

Last Name _____ First Name _____ MI ____ Sex _____ Date of Birth _____

Phone (check preferred #): ☐ Home _____ ☐ Work _____ ☐ Cell _____

Email _____ SS# Last 4 _____ Date of last exam _____

Address _____ City _____ State _____ ZIP _____

Employer _____ Occupation _____ Preferred Pharmacy _____

Family members that are patients at our office _____ Who can we thank for referring you? _____

PRIMARY MEDICAL INSURANCE

Name _____ Address _____ City _____ State _____ Zip _____

Insured's First Name _____ Insured's Last Name _____ Insured's DOB _____ Group # _____ Policy # _____

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐Married ☐ Other
☐ FT student ☐ PT student ☐ Employed

SECONDARY MEDICAL INSURANCE

Name _____ Address _____ City _____ State _____ Zip _____

VISION INSURANCE
☐ EyeMed ☐ VSP ☐ Davis ☐ Spectera ☐ Other: _____

MEDICAL HISTORY

Constitution:
- ☐ Negative
- ☐ Developmental Disabilities
- ☐ Cancer
- ☐ Fatigue Syndrome
- ☐ Other: _____

ENT:
- ☐ Negative
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis
- ☐ Other: _____

Neuro:
- ☐ Negative
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Stroke/CVA
- ☐ Migraine
- ☐ Autism Spectrum Disorder
- ☐ Other: _____

Psych:
- ☐ Negative
- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Other: _____

Cardio:
- ☐ Negative
- ☐ Hypertension
- ☐ Stroke/CVA
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congest Heart Failure
- ☐ Other: _____

Respiratory:
- ☐ Negative
- ☐ Cigarette Smoker
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea
- ☐ Other: _____

Gastro:
- ☐ Negative
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ Other: _____

Urinary:
- ☐ Negative
- ☐ Kidney Disease
- ☐ Prostate Disease/Cancer
- ☐ STD- herpetic/chlamydia
- ☐ Benign Prostate Hypertrophy
- ☐ Pregnant
- ☐ Nursing
- ☐ Herpes
- ☐ Chlamydia
- ☐ Other: _____

Musc/Skel:
- ☐ Negative
- ☐ Osteoarthritis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Other: _____

Integumentary:
- ☐ Negative
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Herpes Simplex/Cold Sores
- ☐ Herpes Zoster/Shingles
- ☐ Other: _____

Endocrine:
- ☐ Negative
- ☐ Type 2 Diabetes Mellitus
- ☐ Type 1 Diabetes Mellitus
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction
- ☐ Other: _____

Hem/Lymph:
- ☐ Negative
- ☐ Anemia
- ☐ Large-volume blood loss
- ☐ Ulcer
- ☐ High Cholesterol
- ☐ Other: _____

Allergy/Imm:
- ☐ Negative
- ☐ Drug Allergies
- ☐ Environmental Allergies
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjogren's Syndrome
- ☐ Other: _____

MEDICATIONS
Please list all current medications (including dosage)

_____
_____
_____
_____
_____
_____

ALLERGIES
Please list any drug allergies that you have

_____
_____
_____
_____
_____
_____

_____
All medical/optical providers that you see

OCULAR HISTORY

☐ Negative ☐ Glaucoma
☐ Macular Degeneration ☐ Dry eye
☐ Keratoconus ☐ "Lazy" eye
☐ Retinal Degeneration / Hole / Tear / Detachment
☐ Injury: _____
☐ Surgery: _____
☐ Other: _____

SOCIAL HISTORY

Alcohol: ☐ No ☐ Yes, Amount _____
Tobacco Use: ☐ No ☐ Yes: ☐ Former ☐ Cigarettes
☐ Smokeless ☐ Vape ☐ Other: _____
Hobbies/Activities: _____

IMMEDIATE FAMILY OCULAR HISTORY

☐ Glaucoma Relationship:_____
☐ Macular degeneration _____
☐ Cataract _____
☐ Retina disorder _____
☐ Other: _____

CONTACT LENS HISTORY

Do you currently wear contact lenses? ☐ No ☐ Yes
Modality: ☐ Daily ☐ 2 Week ☐ Monthly
Brand: _____ Solution: _____
Are you interested in wearing contact lenses?
☐ No ☐ Yes

COVID-19 DISCLOSURE

Any known exposure to COVID-19 or any fever / symptoms in the last 14 days? ☐ No ☐ Yes

ACCESS TO RECORDS

I give permission for the following person(s) to have access to my health records from Chizek Family Eyecare:

_____ _____ _____

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have had the chance to review the Notice of Privacy Practices and upon request may have a copy. The patient's portion is to be paid at the time services are rendered unless other arrangements are made in advance. The undersigned will be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees in addition to the account balance due. The will be a service charge on all returned checks. Professional services are not refundable and all product sales are final. Any returns that are approved may be subject to a restocking fee. I authorize payment from my insurance to be paid directly to Chizek Family Eyecare. I understand that billing any out of network insurance will be my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. I authorize the use of this form on all insurance submissions and the release of all information to my insurance companies. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I permit a copy of this authorization to be used in place of the original.

Patient Signature: _____