NORTHWEST EYE CLINIC

MEDICAL HISTORY

Name _____ Date of Birth: _____ Height: _____ Weight _____

EYE HISTORY
☐ Glasses ☐ Contacts ☐ Glaucoma ☐ Dry Eye
☐ Cataracts ☐ Retina ☐ Macular Degeneration
☐ Previous eye surgeries _____

RESPIRATORY
☐ Asthma ☐ Bronchitis ☐ COPD ☐ Emphysema
☐ Sarcoidosis
☐ Other _____

RENAL
☐ Bladder / Kidney Disease / Stones
☐ Dialysis ☐ other _____

HEART
☐ High Blood Pressure ☐ Congestive Heart Failure ☐ Stents
☐ Mitral Valve Prolapse / Murmur ☐ Pacemaker / Defibrillator
☐ Bypass ☐ Heart Attack ☐ Arrhythmia / Atrial fibrillation
☐ Other _____

ENDOCRINE
☐ Diabetes, How Long? _____
☐ Insulin Dependent ☐ Diet Controlled
☐ Thyroid Hypo / Hyper

NEURO
☐ Stroke ☐ Fainting spells ☐ Seizures ☐ Bell's Palsy
☐ Numbness ☐ Myasthenia Gravis ☐ Other _____

BLOOD DISORDERS
☐ ANEMIA ☐ Sickle Cell Anemia ☐ Hepatitis ☐ Leukemia
☐ HIV / AIDS ☐ Other _____

MUSCULOSKELETAL
☐ Chronic Headaches / Migraines ☐ Implantable Devices
☐ Assistive devices: Cane / Walker / Wheelchair
☐ Rheumatoid Arthritis ☐ Arthritis ☐ Back / Neck Pain

FAMILY HISTORY
☐ Glaucoma ☐ Diabetes ☐ heart disease ☐ Skin Cancer

CANCER
☐ History of Cancer Type _____

OTHER
☐ Former smoker ☐ Currant smoker ☐ Currant vaper
☐ Past Drug Use Yes / No
Alcohol Intake ☐ None ☐ Socially ☐ 1-3 weekly ☐ Daily

SURGICAL HISTORY
Have you had any issues with anesthesia ☐ yes ☐ no
_____
_____
_____
_____

ALLERGIES
☐ Betadine ☐ Latex ☐ Fluorescein Dye / Contrast Dye
☐ Sulfa ☐ Penicillin ☐ Other
_____
_____

MEDICATION LIST	DOSE

1400 E Golf Road, Suite 212, Des Plaines, IL 60016
Phone: 847-296-4020 Fax: 847-984-1894
Leonard G. Bendikas, M.D.
Michael J. Paxhia, M.D.

PERSONAL INFORMATION

Patient Name _____ Date of Birth _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone:_____ Alt _____

Email address: _____@ _____

Social Security No: _____ - _____ - _____ Gender: ☐ Male / ☐ Female / ☐ Non-Binary

☐ Married (spouse's name: ____ _____) / ☐ Divorced / ☐ Single / ☐ Widowed

Race/Ethnicity _____ Language spoken at home _____

Alternate Contact or Caregiver _____ Relationship: _____

Alternate contact Phone No:_____

- ❖ Do you currently live in a skilled nursing facility? ☐ Yes ☐ No
- ❖ May we leave voice message regarding test results or medical information on your personal voicemail ☐ Yes ☐ No

INSURANCE INFORMATION

Primary Insurance Name _____ Supplement / Secondary _____

- ❖ Will you be paying privately for your exam today? ☐ Yes

PHYSICIAN INFORMATION

Referring Physician _____ City or Phone _____

Primary Care/Internist _____ City or Phone _____

Endocrinologist _____ City or Phone _____

WORKER'S COMPENSATION OR AUTOMOBILE ACCIDENT RELATED? YES / NO

Employer _____ Contact Name _____

Responsible Party Name _____ Phone _____

Date of accident / Injury: _____ Case/Claim No: _____

By signing below, you agree with the terms and policies of Northwest Eye Clinic, Ltd. **Assignment of Benefits (AOB)** means that you allow your insurance company to pay Northwest Eye Clinic, Ltd., directly for the services you receive. Instead of you handling the payment, your provider will take care of it with your insurance company. **HIPAA:** By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. I understand that I have the right to revoke this authorization at any time by providing written notice to [Healthcare Provider]. **Dilation Summary:** Dilation involves using eye drops to widen the pupil, allowing for a better view of the inside of your eye. This procedure may cause temporary blurred vision and light sensitivity. It is recommended to bring sunglasses and avoid driving immediately after your appointment. **Spectacle Prescription Release:** Your spectacle prescription will be provided to you electronically to your patient portal automatically and upon request. Please sign below to confirm receipt of your prescription. **Refraction Charge:** Refraction is the process of determining your prescription for glasses or contact lenses. This procedure is not covered by Medicare and some other insurance companies. If your insurance does not cover the refraction, you will be responsible for $50 **Authorization:** I hereby authorize Northwest Eye Clinic to release my healthcare & billing information to the alternate contact listed above. I understand that this information may include details about my medical history, treatment, and other relevant health information.**CC Authorization:** I authorize Northwest Eye Clinic, Ltd. to swipe and keep my credit card information on file for future transactions. I understand that my information will be stored securely and not used without my authorization.

Signature X _____ Date _____

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