Mill Creek Family EYE Center

Confidential Patient Information

Patient: (circle one) Mr. Mrs. Miss Ms. Dr. Other_____ Date: _____

_____ Birthdate: _____ Gender: M / F

First MI Last

Marital Status: Single / Married / Widowed / Divorced / Separated Social Security #:_____

Race: (Circle One) Caucasian / American Indian / Alaska Native / Native Hawaiian / Asian

East Indian / African American / Hispanic / Pacific Islander / Other

Home Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: Home: (____) _____ Work: (____) _____ Cell: (____) _____ Text Ok: Y / N

Email: _____Communication Preference (circle one): Email Phone Mail Text

Employer/School: _____ Occupation/Grade: _____

Person Responsible for Account: _____ Relationship: _____

Address & Phone (if different):_____

Insurance Information

Primary:

Vision Insurance: _____ID #:_____ Group #:_____

Medical Insurance: _____ ID #:_____ Group#: _____

Subscriber's Name: _____Relationship to Patient: _____

Subscriber's Birthdate_____ Subscriber's SS#_____ Subscriber's Employer: _____

Secondary:

Vision Insurance: _____ID #:_____ Group #:_____

Medical Insurance: _____ ID #:_____ Group#: _____

Subscriber's Name: _____Relationship to Patient: _____

Subscriber's Birthdate_____ Subscriber's SS#_____ Subscriber's Employer: _____

How did you hear about our office? (Circle one) Insurance List / Google/ Saw Sign / Personal Referral/Yelp
Advertisement / Walk In / Internet / Word of Mouth / Employee Referral / Other

Whom may we thank for referring you: _____

MILL CREEK FAMILY EYE CENTER
FINANCIAL POLICY

1. NO INSURANCE COVERAGE: Full payment is expected at the time services are rendered and materials are ordered (eyeglasses, contact lenses, etc.).

2. INSURANCE COVERAGE: As a courtesy, we contact your vision and medical insurance prior to your appointment in order to estimate your eye care benefits. The information we receive from your insurance company is only a quote. Please know that quoted benefits are not a guarantee of payment and actual coverage will be determined when your claim is processed by your insurance carrier. You are responsible for knowing the limitations of your insurance contract as well as your eligibility for coverage. Should your insurance deny your claim or eligibility for coverage, you are responsible for all fees accrued.

   CONTRACTED: Our office will bill insurance carriers we are contracted with for covered services and materials. Payment for co-pays and non-covered charges are expected at the time services are rendered. After 60 days, any unpaid balance from the insurance becomes your responsibility.
   NON-CONTRACTED: Our office will not await payment from non-contracted insurance carriers. We will gladly provide an itemized statement for you to submit to your insurance company. _____
   Initials

3. I have chosen to have the optomap/digital imaging service as part of my exam in lieu of dilation. Should my insurance not fully cover this service, I am responsible for applicable charges. _____
   Initials

4. Eyeglass lenses are custom made and **cannot** be refunded. _____
   Initials

5. ACCOUNTS WITH OUTSTANDING BALANCES: You will receive a statement at the beginning of the month. The balance is due before the end of the month; if full payment has not been received by the end of the month, the account will be past due and a 1.5% finance charge (18% APR) will be added to the balance. Returned checks are subject to a $25.00 processing fee.
6. INITIATION OF COLLECTION PROCEEDINGS: All accounts that are 90 days past due will be referred for collection proceedings. In the event collection proceedings are initiated, you will be responsible for any and all collection fees, i.e., attorney fees, court costs, etc.

I have read, understand and agree to follow the Financial Policy of Mill Creek Family Eye Center. I understand that I am ultimately responsible for payment of the account. I authorize payment of insurance benefits to this office. I also authorize release of any medical records necessary to process any claims.

Signature of Responsible Party: _____Date: _____

Notice of Privacy Practices (Acknowledgment of Receipt): I acknowledge that I have reviewed a copy of the Notice of Privacy Practices of Mill Creek Family Eye Center effective date April 14, 2003. I have been made aware that a copy is available if I desire one for my own records.

Signature: _____ Patient Name: _____Date: _____

(You are entitled to a copy of this agreement. Please let the receptionist know if you would like a copy) *05/17*

Medical History Questionnaire

Name:_____

Birth date: _____ Date: _____

Please circle Yes (Y) or No (N) to the following questions:

Have you been diagnosed with any of the following:			
Y	N	Hypertension (High Blood Pressure)	
Y	N	High cholesterol	
Y	N	Heart Disease	
Y	N	Cancer (Date & Type)	
Y	N	Pre-diabetes	When were you diagnosed:
Y	N	Diabetes Type 1 or Type 2 (circle one)	List most recent A1c: Average blood sugar:
Y	N	Thyroid Disorder	
Y	N	Sexually Transmitted Disease	
Y	N	Migraine	
Y	N	Asthma	
Y	N	Anxiety or Depression (circle which applies)	

Please list any other medical conditions: _____

Have you been diagnosed with any of the following eye conditions: **IF YES, IN THE SPACE PROVIDED PLEASE WRITE IN WHEN & WHERE**		
Y	N	Diabetic Retinopathy
Y	N	Cataracts
Y	N	Macular Degeneration
Y	N	Dry eye
Y	N	Retinal detachment
Y	N	Glaucoma
Y	N	Strabismus (eye turn)
Y	N	Amblyopia (lazy eye)
Y	N	Keratoconus
Y	N	Iritis

Have you ever had any of the following ocular surgeries or treatments: **IF YES, IN THE SPACE PROVIDED PLEASE WRITE IN WHEN & WHERE**		
Y	N	LASIK
Y	N	PRK
Y	N	Avastin or Lucentis injection
Y	N	Retinal laser treatment
Y	N	Cataract surgery
Y	N	Patching therapy
Y	N	Vision Therapy

Please list any other eye problems, treatments or injuries:_____
Do you take any medications or supplements? Yes No
If yes, list all prescription and over the counter medications and with the dosage: _____
_____
Are you allergic to any medication? Yes No
If yes, please list:_____
_____
Do you use any eye drops? Yes No
If yes, please list: _____
_____
Do you suffer from any allergies? Yes No
If yes, please list:_____
_____
Are you currently pregnant? Yes No Are you currently nursing? Yes No

If adopted please check box ☐

Do you have a family history of?			Mother	Father	Sibling	Aunt	Uncle	Paternal Grandparent	Maternal Grandparent
Y	N	Glaucoma							
Y	N	Macular degeneration							
Y	N	Color blindness							
Y	N	Blindness							
Y	N	Diabetes							
Y	N	Heart disease							
Y	N	Cancer							
Y	N	High Blood Pressure							
Y	N	High cholesterol							

Do you currently smoke? Yes No If Yes, _____packs per day _____how many years
Are you a former smoker? Yes No If yes, _____ years smoked _____ when did you quit
Do you consume alcohol? Please circle: None/ Daily/ Socially /Alcohol Dependent/ Above average
Do you use any recreational drugs? Yes No If yes, please list _____
Have you ever had a blood transfusion? Yes No If yes, when _____

Contacts:

Do you wear contact lenses? Yes No Are you interested in contacts? Yes No
If yes, please answer the following:
What brand of contacts do you wear?_____
Are you happy with your contacts? Yes No
How often do you throw your contacts away/change your contacts?_____
What contact solution do currently you use?_____
How many hours a day do you wear your contacts? _____
Do you ever sleep in your contacts? Yes No

Previous Eye Exam:

Last eye exam _____ Doctor/Clinic_____City _____
Primary doctor _____City _____Phone_____ Last Visit _____