MITCHELL
FAMILY EYE CARE

Patient Information

Name: (Last) _____ (First) _____ (M) _____ Nickname: _____

Gender: Male Female Birth Date: ____/____/_____ Social Security #: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

Email Address: _____ Occupation: _____

Cell Phone:_____ Employer: _____

Text reminders? ☐Yes, please ☐No thank you Marital Status: _____

Responsible Party Information

Person responsible for patient account: _____Relation to patient: _____

Social Security #: _____ Date of Birth: ___/___/_____ Occupation: _____

Address: _____ Employer: _____

Health/Medical Insurance Information

Primary Insurance: _____ ID #:_____ Policyholder Name: _____

Policyholder Social Security#:_____ Date of Birth:___/___/___ Relation to patient: _____

Policyholder Address (if different): _____

Secondary Insurance: _____ ID #:_____ Policyholder Name: _____

Policyholder Social Security#:_____ Date of Birth:___/___/___ Relation to patient: _____

Policyholder Address (if different): _____

Vision Insurance Information

Vision Insurance: : _____ ID #:_____ Policyholder Name: _____

Policyholder Social Security#:_____ Date of Birth:___/___/_____ Relation to patient:_____

Financial Authorization

I hereby give consent to Mitchell Family Eye Care and/or any doctors at this location to provide eye care services to myself and/or to any party for which I am legally responsible. I understand that regardless of my insurance status, I am ultimately responsible for any charges incurred by me or by any party for which I am legally responsible.

Signed: _____ Date: _____

Information Authorization

I authorize use of this signature for all of my insurance submissions. I authorize payment of benefits directly to Mitchell Eye Care Associates and/or to my doctor. I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of the original.

Signed: _____ Date: _____

How did you hear about our office?

☐Yellow pages ☐Internet ☐TV ☐Insurance company ☐Referred by _____ ☐Other: _____

About Your Insurance

There are two types of "insurance" you may have which will help pay for your eye care services and products. Our practice accepts both:

1. Vision care plans (such as VSP and EyeMed)
2. Medical insurance (such as Blue Cross/Blue Shield and Medicare).

3. Vision care plans are not insurance, and cover only routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening, and do not cover diagnosis, management or treatment of eye diseases.
4. Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
5. If you have both types of plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
6. We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.
7. It is your sole responsibility to provide accurate and up-to-date information regarding any insurance and/or vision plan coverage. Any failure to provide accurate and timely insurance and vision plan information *prior to the time of service* may result in financial responsibility for services rendered.

I have read and agree with these policies.

_____ _____
Patient signature (parent if child) Date

Refraction Charges

One of the most important parts of your eye exam today is the refraction. That is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. While it is a precise and highly technical procedure, it is NOT a covered service by Medicare and many other insurance plans. These plans consider refraction a "vision" service not a "medical" service. Our office fee for refraction is $45, and unless your plan automatically covers the refraction charge, this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at time of service. I understand that any co-payment, coinsurance or deductible I may have are separate from and not included in the refraction fee.

Signature: _____

OR:

I decline the refraction service today. I understand that without the refraction, Dr. Mitchell may not be able to fully assess the health and function of my eyes.

Signature: _____

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Medical History Questionnaire

GT: Y N M

CL: Y N

Name: _____ Birth Date: _____/_____/_____ Today's Date: _____

Race/Ethnicity: _____ Last Eye Exam: _____

Currently wearing: ☐Glasses ☐Contact lenses Last Eye Doctor: _____

Preferred Pharmacy: _____ Current Medical Dr.:_____

(please include location) _____ Last Medical Exam: _____

Medical History

Allergies to medications? ☐Yes ☐ No If yes, please list/explain: _____

_____

Please list all medications you are currently taking (including aspirin, contraceptives, over the counter medications, supplements):

_____

_____

_____

Please list all major surgeries and/or hospitalizations:

_____

_____

Family History

Have any of your relatives, living or deceased, had any of these conditions?

Ocular Disease/Condition	Yes	No	Not Sure	Relationship to You
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed eye/lazy eye	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____

Systemic Disease/Condition	Yes	No	Not Sure	Relationship to You
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other: _____	☐	☐	☐	_____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you wish.

☐ Yes, I would prefer to discuss my social history directly with the doctor (check box and complete side 2)

Do you drive? ☐Yes ☐ No If yes, do you have any difficulty when driving? ☐Yes ☐No If yes, please describe:

_____

Do you use tobacco products? ☐Yes ☐No If yes, type/amount/how long:

Do you drink alcohol? ☐Yes ☐No If yes, type/amount/how long:

Do you use illicit/illegal drugs? ☐Yes ☐No If yes, type/amount/how long:

Have you ever had a blood transfusion? ☐Yes ☐No

Have you ever been exposed to or infected with any sexually transmitted disease(s)? ☐Yes ☐No

Review of Systems

Please indicate if you have problems in any of the following areas:

System	Yes	No	Not Sure
Constitutional			
Fever, Weight Loss/Gain	☐	☐	☐
Skin Disorders/Disease	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Eyes			
Blurred vision	☐	☐	☐
Loss of vision/side vision	☐	☐	☐
Distorted vision/haloes	☐	☐	☐
Flashes of light	☐	☐	☐
Floaters in vision	☐	☐	☐
Dry/Sandy/Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Eye pain/soreness/aching	☐	☐	☐
Redness	☐	☐	☐
Tearing/watering eyes	☐	☐	☐
Mucous discharge	☐	☐	☐
Glare/light sensitivity	☐	☐	☐
Tired eyes	☐	☐	☐
Sties/eyelid infection(s)	☐	☐	☐
Glaucoma	☐	☐	☐
Retinal disorder/disease	☐	☐	☐
Endocrine			
Thyroid disease	☐	☐	☐
Diabetes	☐	☐	☐
Other glandular disease	☐	☐	☐
Immune System disorders	☐	☐	☐

	Yes	No	Not Sure
Ears, Nose, Mouth, Throat			
Allergies (Seasonal/Environmental)	☐	☐	☐
Sinusitis/sinus disorder	☐	☐	☐
Head cold	☐	☐	☐
Chronic cough	☐	☐	☐
Dry mouth/throat	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Vascular/Cardiovascular			
Diabetes	☐	☐	☐
Heart Problems	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Vascular Disease	☐	☐	☐
Gastrointestinal			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Genitourinary			
Kidney/bladder/genital disorder	☐	☐	☐
Bones/Joints/Muscles			
Rheumatoid Arthritis	☐	☐	☐
Other arthritic condition	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Lymphatic/Hematologic			
Anemia	☐	☐	☐
Bleeding problems	☐	☐	☐
Psychiatric disorder/disease	☐	☐	☐

Please list any other pertinent information that you feel may be important in the care of your eyes (including history of prior diagnoses of cataracts, high pressure in eyes, ocular growths, ocular surgery, etc):

_____

_____

_____

_____

_____

(Office use only)

GT: Y N M **GLC** **DM**

CL: Y N M

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FAMILY EYE CARE

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY

I hereby acknowledge that I have received a copy and/or read the (HIPPA) Health Insurance Portability and Accountability Act.

_____
(printed name)

_____ _____
(signature) (date)
(parent or legal guardian, if minor)

PERMISSION TO RELEASE MEDICAL RECORDS

I _____, hereby give permission to release any and all medical information obtained during the course of any examinations to the following individual(s):

_____ _____
(name) (relationship)

_____ _____
(name) (relationship)

_____ _____
(name) (relationship)

Signed:_____ Date:_____