Lakeville Family Eye Care, P.A.

17690 Kenwood Trail Lakeville, MN 55044 Phone (952) 898-9588, Fax (952) 898-2030

Medical History

Date: ______/______/______

Last Name: ___________________________ First Name: _______________________ DOB: _____/_____/_____

CASE HISTORY / REASON FOR VISIT:

Date of Last Medical Exam: _____/_____/_____ Primary Physician / Clinic: _____________________________

Date of Last Eye Exam: _____/_____/_____ Clinic / Eye Doctor's Name: ____________________________

Do you wear **glasses**? YES / NO All the time Occasionally Office Work Reading only Driving Only

Do you wear **contacts**? YES / NO Type: ________________________ Replace Schedule: ___________________

How many hours per day do you use a **computer**: ____

What are your **Activities/Hobbies**:
☐ Golf ☐ Boating ☐ Hunting ☐ Gardening ☐ Other: ____

Have you ever had **eye injuries**? YES / NO Which Eye? ____

Have you ever had **eye surgeries**? YES / NO Why? ____

Have you ever taken **eye medication**? YES /NO Why? ____

Have you ever been diagnosed with?
☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Retinal Detachment ☐ Other: _______________

When were you diagnosed? ____

Please check any of the following past or present conditions that apply:

☐ Blurred Vision – Distance	☐ Burning Eyes	☐ Floaters or Spots	☐ Headaches
☐ Blurred Vision – Near	☐ Itchy Eyes	☐ See Flashes	☐ Migraine Headaches
☐ Glare	☐ Dry Eyes	☐ Double Vision	☐ Loss of Vision
☐ Eye Strain	☐ Red Eyes	☐ Poor Night Vision	☐ Crossed Eyes
☐ Light Sensitive	☐ Watery Eyes	☐ Poor Color Vision	☐ Eye Infections

Are you currently **pregnant** or **nursing**? YES / NO

PLEASE TURN THIS FORM OVER AND COMPLETE OTHER SIDE

Personal Medical History (Review of Systems) PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, **PLEASE CHECK NONE.**

Cardiovascular: _____**none**	**Endocrine:** _____**none**	**Respiratory:** _____**none**
☐ Hypertension ☐ Stroke ☐ Heart Disease ☐ Vascular Disease ☐ Other: ☐ Medications:	☐ Non-Insulin Dependant Diabetes ☐ Insulin Dependant Diabetes ☐ Thyroid Problem ☐ Hormonal Dysfunction ☐ Other ☐ Medications:	☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ COPD ☐ Other: ☐ Medications:
Constitutional: _____**none** ☐ Cancer ☐ Trauma/Large Volume Blood Loss ☐ Developmental Disability ☐ Other ☐ Medications:	**Genitourinary:** _____**none** ☐ Kidney Disease ☐ Urinary Tract Infection ☐ STD – Herpetic/Chlamydia ☐ Other ☐ Medications:	**Psychiatric:** _____**none** ☐ ADHD ☐ Depression ☐ Schizophrenia ☐ Other ☐ Medications:
Neurological: _____**none** ☐ Multiple Sclerosis ☐ Epilepsy ☐ Cerebral Palsy ☐ Tumor ☐ Other ☐ Medications:	**Musculoskeletal:** _____**none** ☐ Osteoarthritis ☐ Fibromyalgia ☐ Muscular Dystrophy ☐ Ankylosing Spondylitis ☐ Other ☐ Medications:	**Immunologic:** _____**none** ☐ AIDS or HIV ☐ Rheumatoid Arthritis ☐ Lupus ☐ Neurofibromatosis ☐ Other ☐ Medications:
Hematological _____**none** ☐ Anemia ☐ Leukemia ☐ Other ☐ Medications:	**Gastrointestinal:** _____**none** ☐ Crohn's ☐ Colitis ☐ Celiac Sprue ☐ Other ☐ Medications:	**Ear/ Nose / Throat:** _____**none** ☐ Hearing Loss ☐ Upper Respiratory Infection ☐ Other ☐ Medications
Dermatologic _____**none** ☐ Eczema ☐ Rosacea ☐ Psoriasis ☐ Other ☐ Medications:	**Allergies** (please list) _____**none** Drug: Environmental:	**Alcohol Use** **Yes / No** Amount per Week: **Tobacco Use** **Yes / No** Amount per Day:

Please list any medications and/or drugs that you are taking (including herbal) that are not listed above:

____

____

Family History: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) ever been diagnosed with:

Disease / Condition

Blindness:	Yes / No	Who? ____________________
Cataracts:	Yes / No	Who? ____________________
Glaucoma:	Yes / No	Who? ____________________
Crossed Eyes:	Yes / No	Who? ____________________
Macular Degeneration:	Yes / No	Who? ____________________
Retinal Detachment:	Yes / No	Who? ____________________
High Blood Pressure	Yes / No	Who? ____________________
Diabetes	Yes / No	Who? ____________________
Cancer:	Yes / No	Who? ____________________
Heart Disease	Yes / No	Who? ____________________
Thyroid Disease	Yes / No	Who? ____________________

Reviewed by:

Dr.______________________________________ Date_____/_____/_____

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Patient Information

Name:____ Date of Birth:__________________
First MI Last

Home Phone: ________________________ Work: ____________________ Cell:_________________________

Address: ____
Street City State Zip

Last 4 digits SS#: _________________________ Email address____

Employer/School________________________________ Occupation_____________________________ FT / PT

Spouse/Partner ____

Please Circle your Preferences below

Communication Email / Mail / Phone **Language** English / Spanish / other
Ethnicity Not Hispanic or Latino/ Hispanic or Latino / Native Hawaiian or other Pacific Island
Race White / Asian / Hispanic / Black or African Amer / Amer Indian or Alaska Native / Native Hawaiian or Pacific Island

How did you find Us?
☐ **Walk In** / Drive By ☐ An Aquaintance Recommend this clinic:______________________________________
☐ Phone Book (Dex / Frontier / Yellow Book / Verizon / Not Sure)
☐ **Internet:** google / yahoo / Bing / yellowbook.com / msn /other: _______________________________________
☐ Employer ☐ My Insurance ☐ Newspaper ☐ Mailer / Postcard
☐ Bulletin Ad ☐ I am a previous patient ☐ Professional Referral (Dr's Name:_____________________________
☐ Family Member ☐ **OTHER:**

Insurance Information

Primary Medical: ______________________________
Secondary or Vision Ins.: ____________________________

Policy Holder's Information

Name: ________________________ DOB________
Name: ________________________ DOB ________

Complete if patient is under age 18 or in guardian's care

Parent/guardian's Name: ____ Relationship___________________
Address: ____
Street City State Zip
Home Phone: __________________________ Work: ____________________ Cell: __________________________

Lakeville Family Eye Care, P.A. will be happy to file your insurance claim on your behalf. **However, any benefits quoted by us or relayed from your insurance carrier(s) are only an estimation of benefits, not a guarantee of coverage. A final determination cannot be made until a claim is processed by your insurance carrier(s).** While we are willing to check for you, knowing your insurance benefits and restrictions are ultimately your responsibility. If your insurance company or policy requires a referral or prior authorization, it is **your** responsibility to make sure that this is obtained before services are provided. If services provided are not covered by your plan or are not of the contractual obligation with that carrier, the bill remains your responsibility.

Signing below acknowledges the Following:
**This waiver shall stay in effect from the date shown below going forward until rescinded by Lakeville Family Eye Care*
**That I was Informed and offered Lakeville Family Eye Care's Notice of Privacy Practices (HIPPA)*
*I authorize Lakeville Family Eye Care to release or request my medical records to or from any previous providers.
*I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

Signed_______________________________________ Print Name:_______________________________ Date:_________

DIGITAL RETINAL IMAGING

Lakeville Family Eye Care believes that using the best technology is crucial to maintaining good ocular health and preventing ocular diseases from going undiagnosed. As a result, we utilize Digital Retinal Imaging or Photography, which produces a high definition picture of your retina, interior blood vessels, and optic nerves. These images are vital in helping our doctors assess your risks for serious ocular disease.

❒ Yes, I would like to have Digital Retinal Imaging performed today (additional fee of $39)

❒ No, contrary to our Doctor's recommendation, I am refusing retinal photos & understand the health risks involved.

❒ I would like to discuss this with one of the Doctors before deciding.

Vision Insurance vs. Medical Insurance

We often have patients that have both vision and medical insurance. They are very different in terms of the services they cover and it's important for our patients to understand those differences. Vision coverage is mainly designed to determine a prescription for glasses and is not equipped to deal with complex medical conditions and/or diagnoses and does not include a detailed examination of the retina. When a medical diagnosis or condition is present (such as high blood pressure, diabetes or eye disease) it is necessary to file the visit with your major medical carrier and the co-pays for that insurance will apply as well as any non-covered service. **Our office does not make these rules and they are defined by the insurance carriers themselves**. There is no way to know prior to the examination which type of insurance our office will be able to file for you. We make every effort to be on every major carrier for your convenience and we will file those claims for you. In the event that we do not take your major medical/vision insurance, we will provide you with an itemized receipt so that you may file with your carrier for reimbursement. If you have any questions, please let us know.

I understand the paragraph above and authorize Lakeville Family Eye Care to file my insurance.

____ ________/________/________

Patient Signature Today's Date