Welcome to Mascoutah Eye Care
PATIENT HISTORY

Referred by:

Today's Date: _____ - _____ -_____ ☐ Insurance ☐ Our Website ☐ Friend ☐ Other: _____

Name: (Last) _____ (First) _____ (MI) _____

Birth Date: ____ - ____ - ____ Age: _____ Home Phone: _____ Work/Cell: _____

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

Email: _____ Hours Computer Use/Day: _____

Occupation *(If full-time student, name of school)*: _____

Marital Status: ☐ Single ☐ Married ☐ Other

If under the age of 18, Parents Name: _____

INSURANCE INFORMATION:

Vision/Medical Insurance: _____ Social Security #: _____ - _____ -_____

Primary Card Holder: _____

Primary's Birth Date: ____ - ____ - ____ Employer: _____

VISUAL AND MEDICAL HISTORY:

Reason for today's visit: ☐ Glasses Exam ☐ Contact Lens Exam ☐ Red Eyes ☐ Other: _____

Glasses currently worn: ☐ Distance Only ☐ Near Only ☐ Bifocal ☐ No-line Bifocal ☐ Trifocal

Date of last eye exam: _____ Name of Doctor:_____

Are you interested in learning about **Lasik Surgery**? ☐ Yes ☐ No

Date of last medical exam: _____ Name of Doctor: _____

Medications you are currently taking (including over-the-counter):

_____

Please list any drug allergy: _____ Seasonal allergy: ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Smoking frequency:_____

Please check the following that apply to you and/or your immediate family members:

	SELF	FAMILY (List Relationship)		SELF	FAMILY
Diabetes	_____	_____	Eye Injury	_____	_____
High Blood Pressure	_____	_____	Floaters/Flashes	_____	_____
Arthritis	_____	_____	Double Vision	_____	_____
Thyroid	_____	_____	Headache	_____	_____
Heart Disease	_____	_____	Lazy Eye	_____	_____
Respiratory Problems	_____	_____	Cataract	_____	_____
Kidney Disease	_____	_____	Glaucoma	_____	_____
Cancer _____	_____	_____	Retinal Disease	_____	_____
Others: _____	_____	_____	Macular Degeneration	_____	_____
Surgery: _____	_____	_____	Eye Surgery	_____	_____

Do you have: *dry eyes? ☐ Yes ☐ No *itchy eyes? ☐ Yes ☐ No *excess tearing? ☐ Yes ☐ No

Do you skip lines or lose your place when reading? ☐ Yes ☐ No

CONTACT LENS INFORMATION:

Do you currently wear contact lenses? ☐ Yes ☐ No If yes, what type?_____

How often do you replace your contact lenses? _____ Do you sleep in your contacts? ☐ Yes ☐ No

Are you interested in bifocal/multifocal contact lenses? ☐ Yes ☐ No

YOU MUST READ AND SIGN THIS SECTION

Financial Assignment & Release

Mascoutah Eye Care

I, the undersigned, assign directly to Mascoutah Eye Care or Dr. Marianne McDaniel all insurance benefits, if any, otherwise payable by me or to me for services rendered.

*I understand that I am financially responsible today for all fees. I also agree that I am financially responsible to reimburse any and all fees for services and materials not collected in full at the date of service or should my insurance or vision plan deny payment for services or materials rendered.

*I further understand that after 60 days from the date of service or claim is filed I agree to pay for any unpaid balances on my account as a result of denial in part or whole from my insurance carrier caused by; unmet deductibles, non-covered materials or professional services, my negligence in fulfilling any paperwork, providing any required information requested of me by my insurance carrier or uncollected fees on service day.

*If you do not inform us that you have a vision plan or medical insurance before services are rendered, we will assume no coverage exists.

* I agree that I am responsible to file my own claim if I discover I have vision or medical benefits after services or products are rendered.

*I agree this office with no exceptions will not back file claims, post authorize claims, or refund fees after services are rendered due to lack of notification of vision or medical benefits.

*We will begin your custom glasses order immediately after receipt of payment. All glasses are custom crafted for each patient's unique vision needs. All glasses lenses are tailored to fit the frame with patient selected.

Cancellations on glasses will not be permitted. Patients may not switch frames after their order has been processed. REFUNDS ARE NOT AN OPTION.

Signature of Responsible Party and Consent to Treat: _____

Starting April 14, 2003, Federal law requires us to inform you of privacy practices regarding patients' records. Copies of these privacy practices are posted in our waiting room. Please print and sign this form that state you have been informed of this regulation. Thank you for your cooperation.

Name: _____

Signature: _____

Date: _____

MASCOUTAH
EYEcare

Mascoutah Eye Care is committed to offering our patients the most through eye health examination available. We now offer **optomap®** ultra-wide field digital retinal imaging to obtain an in-depth view of nearly the entire retina through an undilated pupil. As part of your comprehensive evaluation, **optomap®** helps Dr. McDaniel better view and detect ocular disease and abnormalities, such as macular degeneration, glaucoma, retinal holes, retinal detachments and diabetic retinopathy, in the retina at an earlier and more treatable stage than methods previously available Your image will be obtained today as part of our preliminary testing. Your doctor will review and discuss the **optomap®** images during the exam.

In most cases this technology may alleviate the need for dilation and allows the patient to return to normal activities. Optomap® is prescribed annually by Dr. McDaniel on each patient in order to identify eye health problems and compare changes from year to year.

At Mascoutah Eye Care we consider **optomap®** retinal evaluation an important part of our patients' eye health examination.

Optomap® is an advanced screening procedure that is traditionally not covered by most vision insurance plans. Your fee for this elective diagnostic technology will be $39 unless covered by your insurance. The doctor will let you know if this procedure is covered by your insurance when the image is reviewed.

_____ I elect to utilize optomap® technology today

_____ I decline the use of the optomap® technology and elect for a regular dilated exam

_____ _____

Patient or parent/guardian signature Date