WELCOME TO METZGER EYE CARE!

Please let us know if you need any help filling out your paperwork.

TODAY'S DATE: _____

Name: _____

Street: _____

City: _____ State: ____ Zip Code: _____

Phone: _____ Email: _____

SSN# _____

DOB: ___/___/_____ Age: _____ Gender: M F

Race: _____ Marital Status: S. M. D. W

Preferred Language: _____

Occupation: _____

Employer/School: _____

Avg. Screen Time: _____

Hobbies/Activities: _____

INSURANCE

Vision Insurance: _____

ID#: _____

Medical Insurance: _____

ID#: _____

Subscriber Name: _____

Subscriber DOB: ___/___/_____ SSN# _____

Relationship to patient: _____

Primary Physician: _____

Preferred Pharmacy: _____

CURRENT MEDICATIONS	DOSAGE	TIMES PER DAY

Medication Allergies: _____

OCULAR HISTORY

Reason for Visit: _____

Time since last eye exam: _____

Do you wear glasses? YES NO

Do you wear contact lenses? YES NO

If so, what brand? _____

How often do you replace them? _____

Solution brand: _____

Any issues? _____

Have you ever been diagnosed or treated for any of the following eye problems? *(Y: Yes, N: No, F: Family History)*

Cataracts	Y	N	F	Glaucoma	Y	N	F
Dry/Itchy/Burning	Y	N	F	Lazy/ Crossed Eye	Y	N	F
Eye Injury	Y	N	F	Macular Degeneration	Y	N	F
Flashes/Floaters	Y	N	F	Retinal Detachment	Y	N	F

Eye Surgery (describe): _____

MEDICAL HISTORY

Have you ever been diagnosed or treated for any of the following health problems? *(If Yes: circle Y & include diagnosis, circle N for No, and F for Family History)*

Y N F Allergies _____

Y N F Blood/ Lymph Disorders _____

Y N F Cancer _____

Y N F Diabetes _____

Y N F Digestive/ Gastric _____

Y N F Ear/ Nose/ Throat _____

Y N F Exposure to Hepatitis/ HIV _____

Y N F Kidney Problems _____

Y N F Headaches _____

Y N F Heart Problems _____

Y N F High Blood Pressure _____

Y N F High Cholesterol _____

Y N F Mental Health Diagnosis _____

Y N F Neurological Disorders _____

Y N F Currently Pregnant/ Nursing _____

Y N F Respiratory Problems _____

Y N F Skin/ Muscular Disorders _____

Y N F Substance Abuse History _____

Y N F Thyroid Problems _____

____ Never Smoked ____ Former Smoker

____ Current Smoker (for how long? ____ how much? ____)

Signature of Patient, Guardian, or Representative

_____ **DATE:** ___/___/_____

METZGER EYE CARE

PRIVACY POLICY, PAYMENT POLICIES, & INFORMED CONSENT

PATIENT NAME: _____ **DATE OF BIRTH:** _____

RESPONSIBLE PARTY/ GUARDIAN : _____

ADDRESS: _____

PATIENT EMAIL: **PHONE NUMBER:**

PRIVACY

- I acknowledge that I have been offered the PRIVACY PRACTICES NOTICE (available in our office).
- I authorize release of medical information concerning my illness & treatment by Metzger Eye Care to my insurance company.
- I authorize the release of my personal medical information to any doctor to whom I may be referred.

PAYMENT POLICIES

- I acknowledge that payment for all services & products incurred through visits to this office is the responsibility of the patient or legal guardian, even if the insurance company should deny payment of claim.

We strive to give you accurate information by acting as a liaison between insurance companies and our patients.
We will file all insurance forms if Metzger Eye Care is a participating provider for your plan.

- I understand that I am responsible for knowing what insurance coverage I actively have and will not hold MEC responsible for this information.
- I understand verification of eligibility is not a guarantee of payment as stated by my insurance company.

For your convenience, we accept cash, check, credit cards (American Express, Discover, MasterCard, and Visa), & Care Credit.
There is a returned check fee applied to every returned check.

- I agree to pay all co-pays, deductibles, co-insurances, & non-covered services as determined by my insurance company.
- I agree to pay an additional collection fee for all accounts not paid in the time stated on the final monthly statement.
- I authorize the release of any medical or other information necessary to process my claim.
- I also request payment of government benefits to myself or to the party who accepts assignment below.
- I authorize payment of medical benefits to the undersigned physician or supplier for services described.

INFORMED CONSENT: Dilation & Testing

Our office makes every attempt to provide quality eye care. This requires that your eyes be dilated. Please be aware that your eyes being dilated will impair your ability to read for several hours & may interfere with driving in some instances.

During the course of an examination, your doctor may order additional medical tests that are not considered part of a routine visit. Additional tests will only be performed when medically necessary & may be subject to deductibles, co-insurance, & co-pays.
These additional services include contact lens fitting, visual field evaluations, Optomap imaging, & OCT scans.

I AUTHORIZE METZGER EYE CARE TO DISCUSS MY PROTECTED HEALTH INFORMATION WITH THE FOLLOWING PERSON(S):

NAME	*RELATIONSHIP*

If any of this information changes, it is the patient's responsibility to inform Metzger Eye Care as soon as possible.

Patient or Personal Representative's Signature	*Printed Name*	*Date*