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: ____

<u>Financial Policy</u>

Mill Creek Family Eye Center (MCFEC) and Mill Creek Family Eyewear (MCFEW) are committed to providing the highest level of quality eye care and personal service to our patients. As a courtesy, we contact your vision and medical insurance, prior to your appointment, to get an estimate of your eye care benefits. The information we receive from your insurance company is only a quote. Quoted benefits are NOT a guarantee of payment and actual coverage will be determined when your claim is processed by your insurance carrier.

You, the patient, or the patient's guarantor, are ultimately responsible for all charges associated with your care regardless of insurance coverage. Your insurance plan may specifically exclude or limit examination, vision hardware, and other services. Our office is not involved in setting your coverage, benefits, co-pays, deductibles, exclusions, preventative benefits, waiting periods, or determining if a referral is needed. Coverage and/or benefits issues can best be addressed by your employer, group plan administrator, or insurance carrier directly.

<u>Routine Vision Coverage VS. Medical Coverage</u>
Most patients have both routine/preventative vision insurance as well as non-routine/procedural medical insurance. Often, vision insurance is provided by a separate carrier than your medical insurance, i.e., VSP, Davis Vision, EyeMed. Both types of insurance may pay for all or a portion of your visit and sometimes your visit may be split between vision and medical insurance. Based upon your reason for visit/symptoms, medical history, and any findings during your exam, your doctor will determine how your visit will be billed. Please note, appropriate co-pays, deductibles, and co-insurance will apply.

Our office will bill insurance carriers we are contracted with for covered services and materials. When a claim is submitted on a patient's behalf, insurance benefits will be paid directly to MCFEC or MCFEW. Payment for co-pays and non-covered charges are expected at the time of service. We approximate the amount you owe the day of your visit. Should your insurance carrier deny your claim or eligibility for coverage, you are responsible for all fees accrued, or any remaining balance.

<u>Financial/Communication Consent</u>
You understand and accept the financial policy as outlined above. In addition, you consent to MCFEC and MCFEW and any of its agents acting on their behalf to communicate with you regarding your accounts through various means such as 1) any cell, landline, or text number that you provide, 2) any email address that you provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communication that you provide.

Patient or Guarantor Signature:____

Print Patient Name :_______________________________________Date:__________

Print Guarantor Name:_____________________________________Date:__________

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 _________