Mill Creek Family EYE Center

Confidential Patient Information

Patient: (circle one) Mr. Mrs. Miss Ms. Dr. Other_____ Date: _____

Name: _____ Birthdate: _____ Gender: M / F

First MI Last

Marital Status: Single / Married / Widowed / Divorced / Separated Social Security #:_____

Race: (Circle) 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: _____

Financial Policy

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.

Routine Vision Coverage VS. Medical Coverage

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.

Financial/Communication Consent

I understand and accept the financial policy as outlined above. In addition, I give consent to MCFEC and MCFEW and any of its agents acting on their behalf to communicate with me regarding my accounts through various means such as: 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communication that I provide.

Notice of Privacy Practices (Acknowledgment of Receipt): I acknowledge that I have reviewed a copy of the Notice of Privacy Practices of Mill Creek Family Eye Center effective date April 14, 2003. I have been made aware that a copy is available to me online at: http:www.millcreekeye.com

HIPAA Release : *This will remain in effect until terminated by me in writing.*

I authorize a verbal release of information regarding my account to include ; diagnosis, examinations & appointment information to the following :

[ ] Spouse/Partner :_____ [ ] Relative :_____

[ ] Other :_____ [ ] NOT TO BE RELEASED TO ANYONE.

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 medication and reaction:_____
_____
Do you use any eye drops? Yes No
If yes, please list:_____
_____
Do you suffer from any allergies? Yes No
If yes, please list allergen and reaction:_____
_____
Are you currently pregnant? Yes No Are you currently nursing? Yes No

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							

If adopted please check box ☐

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 _____