

Welcome Back to Our Office



Name: _____ **Date of Birth:** _____
Mailing Address: _____ **SSN:** _____
City: _____ **Zip Code:** _____ **Employer:** _____
Phone Number: _____ **Occupation:** _____
Daytime Phone #: _____ **Marital Status:** _____
Cell Phone #: _____ **Spouse:** _____
Do you accept text messages? Yes or No **Email:** _____

Date of last eye exam (if elsewhere) _____ **Pregnant or Nursing: Yes or No**

Who is your Primary Care Physician? _____

What is the primary reason for your visit today? _____

Do you wear contacts? Yes or No **If no, would you like to try them? Yes or No**

If yes, what brand? _____ **Are you happy with your contacts? Yes or No**

Medications: _____

Allergies to Medications: _____

Tobacco Use: Yes or No **Current or Past** **If yes, how much?** _____

Please list any previous eye surgeries: _____

Please list if you or a relative have ever been diagnosed or treated for the following:

Ocular History	Relationship	Medical History	Relationship
Cataracts	_____	Allergies	_____
Corneal Problems	_____	Asthma	_____
Diabetes	_____	Cancer	_____
Dry Eyes	_____	Cholesterol	_____
Eye Injuries	_____	Migraines	_____
Flashes of Light	_____	High Blood Pressure	_____
Glaucoma	_____	Lupus	_____
Macular Degeneration	_____	Stroke/TIA	_____
Ocular Allergies	_____	Hepatitis A B C (circle one)	_____
Double Vision	_____	Kidney Disease	_____
Cross/Eye turn	_____	Multiple Sclerosis	_____
Floaters	_____	Tuberculosis	_____
Retinal Issues	_____	Thyroid (hyper or hypo?)	_____
Other	_____	Other	_____

Signature of Patient or Guardian: _____ **Date** _____



Patient's Name _____ Date of Birth _____
(Please print)

Cell Phone Number: _____ Texting ok? Yes or No

Email Address (please print legibly) _____

Mailing Address _____

It is our office policy to inform you of our payment procedures. Please review and initial the section below that is applicable. **All accounts not paid within 60 days are subject to a 1.5% interest charge.**

Contact lens services fees are subject to additional fees that are not listed below.

_____ 1. **Patient without Insurance (Private Pay)**

Please make payment for your care at each visit. If payment cannot be made at each visit, arrangement must be made with our billing department prior to your visit.

_____ 2. **Patient with Insurance**

You are responsible for deductibles, co-pays, non-covered services (such as the **Optomap** which is \$39), co-insurance, and items considered "not medically necessary" by your insurance company. Please pay co-payments and co-insurance amounts as services are rendered. The remaining balance should be taken care of within one (1) month of notice from insurance company unless other arrangements are made with our billing department. If you or your insurance carrier make payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, notify the billing department to make other arrangements.

_____ 3. **Medicare**

Our office will submit your Medicare charges to Medicare and your secondary insurance. You are responsible for deductibles, copays, and any non-covered services such as the **refraction (\$20)** and the **Optomap (\$39)**.

I have read and I agree to the financial policy information stated above that applies to me.

Patient (or responsible party) signature

Date

Person signing on behalf of patient (please print name)

Relationship to patient

Brian K. Mitchell, O.D. Tessa C. Johnston, O.D. Kurt Wilkening, O.D. Damon Hanson, O.D.