MIDLAND EYE CARE

Name (Legal/Full) _____ **Sex:** M / F **DOB** _____/_____/_____
First Last Preferred Name

Address_____ **Zip** _____ **SSN #**_____/_____/_____
(18 & over only)

Phone #_____**Cell #**_____**Work #** _____ **Occupation**_____

Guardian(s)_____ **List all family members that are patients here**_____

Referred By _____**Email**:_____**Opt In** ◯ **Out** ◯ **for text/email reminders**

Insurance Information

Policy Holder's Name _____**DOB**_____/_____/_____ **SSN #** (needed for insurance purposes only) _____/_____/_____

VISION INSURANCE _____ **MEDICAL INSURANCE** _____

Policy/Member ID/# _____ **Policy/Member ID/#** _____

Medical History

Group # _____

Date of Last Medical Exam:_____ **Name of Medical Doctor**_____**Dr.'s Phone**_____

What is your general health? Excellent _____ Good _____ Fair _____ Poor_____ **Are you pregnant?** Yes____ No____ **Are you nursing?** Yes____ No____

List all Medications _____

Do you have allergies to any medications? Yes____ No____ **If yes, explain**: _____

Do you have general allergies? Yes____ No____ **Allergic to what?** _____ **What Happens?** _____

Ocular History

Date of Last Eye Exam: _____ **Do you wear eyeglasses?** Yes____ No ____ **If yes Please circle one**- Single vision, Bi-Focal or Progressives?

Do you wear contact lenses? Yes____ No ____ **If yes, what kind?**_____ **Type of solutions/care system**:_____

Current eye drops_____ **List all current or past eye diseases, eye injuries or eye surgeries (Lasik)**_____

Chief Complaint

How may we help you today? Please check any symptoms you are experiencing. **Please note**: Vision insurance may NOT cover an exam if there is a medical reason for visit, such as; loss of vision, headaches, eye pain, eye itching or burning, redness, glaucoma, cataracts, floaters, dry eye, etc.

◯ **Annual Eye Exam** ◯ **Double vision** ◯ **Eye pain/soreness** ◯ **Watery Eyes** ◯ **Flashes of light** ◯ **Mucous Discharge**
◯ **Blurred vision** ◯ **Crossed eyes** ◯ **Glare/Light sensitivity** ◯ **Dry eyes** ◯ **Floaters** ◯ **Styes / Chalazion**
◯ **Loss of vision** ◯ **Red eyes** ◯ **Sandy/gritty feeling** ◯ **Tired eyes** ◯ **Burning/itching** ◯ **Other (Explain)** _____

Social History

This information is a protected part of your medical record and is kept strictly confidential. You may discuss this privately with the doctor.

Do you use tobacco products? Yes / No If yes, type/amount/how long? _____
Do you drink alcohol? Yes / No If yes, type/amount/how long? _____
Do you use illegal drugs? Yes / No If yes, type/amount/how long? _____
Please note if you have ever been exposed to or infected with: HIV ___ Hepatitis _____ Tuberculosis____ Chlamydia____ Gonorrhea_____ Syphilis_____

TURN OVER AND CONTINUE ON THE OTHER SIDE

Review of Symptoms:

Do you currently, or have you ever had any problems in the following areas:

CONSTITUTIONAL		**GASTROINTESTINAL**	
Developmental Disability	Yes/No	Crohn's Disease	Yes/No
Cancer	Yes/No	Colitis	Yes/No
Weight Loss/Gain	Yes/No	Ulcer	Yes/No
EAR, NOSE, THROAT		Acid Reflux	Yes/No
Hearing Loss	Yes/No	Celiac Disease	Yes/No
Sinus Congestion	Yes/No	**GENITOURINARY**	
Dry mouth	Yes/No	Kidney Disease	Yes/No
NEUROLOGICAL		Prostate Disease/Cancer	Yes/No
Multiple Sclerosis	Yes/No	Benign Prostate Hypertrophy	Yes/No
Epilepsy	Yes/No	**MUSCULOSKELETAL**	
Cerebral Palsy	Yes/No	Rheumatoid Arthritis	Yes/No
Tumor	Yes/No	Osteoarthritis	Yes/No
Stroke/CVA	Yes/No	Fibromyalgia	Yes/No
Migraine	Yes/No	Muscular Dystrophy	Yes/No
PSYCHIATRIC		Osteoporosis	Yes/No
Depression	Yes/No	Gout	Yes/No
Attention Deficit	Yes/No	**INTEGUMENTARY**	
Anxiety Disorder	Yes/No	Eczema	Yes/No
Bipolar Disorder	Yes/No	Rosacea	Yes/No
CARDIOVASCULAR		Psoriasis	Yes/No
Hypertension	Yes/No	Herpes Simplex/Cold Sores	Yes/No
Heart Disease	Yes/No	Herpes Zoster/Shingles	Yes/No
Vascular Disease	Yes/No	**ENDOCRINE**	
Congestive Heart Failure	Yes/No	Type 1 Diabetes Mellitus	Yes/No
RESPIRATORY		Type 2 Diabetes Mellitus	Yes/No
Asthma	Yes/No	Thyroid Dysfunction	Yes/No
Bronchitis	Yes/No	**HEMATOLOGIC/LYMPHATIC**	
Emphysema	Yes/No	Anemia	Yes/No
Sleep Apnea	Yes/No	High Cholesterol	Yes/No

Family History

Please note any family history for the following conditions:
(**Parents, Siblings, Children**)

DISEASE/CONDITION		**Relation**
Hypertension	Yes/No	_____
Diabetes -Type 1 or 2	Yes/No	_____
Cancer	Yes/No	_____
Thyroid	Yes/No	_____
Cataract	Yes/No	_____
Glaucoma	Yes/No	_____
Macular Degeneration	Yes/No	_____
Amblyopia (Lazy Eye)	Yes/No	_____
Strabismus (Crossed Eye)	Yes/No	_____
Retinal Detachment	Yes/No	_____
Other		_____

If you have answered YES or have one that is not listed, please explain and describe the problem.

_____

_____

CONSENT FOR TREATMENT: I hereby authorize Highpoint Family Vision to administer diagnostic and medical procedures as may be necessary for proper health care.

HIPAA PRIVACY ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES: I have been offered a copy of Highpoint Family Vision's statement on privacy practices.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Highpoint Family Vision to release any medical or incidental information that may be necessary in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.

MEDICARE AUTHORIZATION: I request payment of authorized Medicare benefits be made on my behalf to Highpoint Family Vision, for any service furnished to me by the doctor/supplier. I authorize the holder of medical information about me to release to Medicare or any other insurance I may have and its agents any information needed to determine these benefits or the benefits payable to related services. In Medicare assigned cases, the doctor or supplier agrees to accept the charge determination of the Medicare carrier at full charge and the patient is responsible only for the deductible, co-insurance and uncovered services. Co-insurance and the deductible is based upon the charge determination of the Medicare carrier.

_____ (Initial Here) I have read and understand all office policies and if a medical diagnosis is determined, my vision insurance may not cover the examination and it will be billed to my medical insurance.

_____ **Date** _____/_____/_____

Patient or Legal Guardian Signature

Midland Eye Care Office Policies and Financial Agreement

Full Payment Required –
Full payment is required for services rendered. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company and I authorize insurance benefits to be paid directly to the provider.

Cancellations –
24 hour notice is required for any cancellation and/or rescheduling. Otherwise a $40 fee may be incurred.

Returned Check Fee –
A fee of $40 will be charged for each returned check.

Proof of Insurance –
Insurance must be provided at time of service in order for a claim to be filed. If requested we can provide a detailed itemized receipt that can be submitted to insurance by the patient.

Routine Exam –
Patients presenting with a medical condition that prevents an accurate glasses prescription may be required to reschedule their routine exam until a later date when the condition has been resolved.

Prescription Verification –
No additional charge for follow-up visits for contact lens and glasses prescriptions within 60 days of initial examination.

Maximum Two Family Member –
We limit the number of appointments per family to two per day.

Examination of Minors –
A parent or legal guardian is required to be in the exam room with any patient under the age of 18.

Outside Frame & Adjustment –
We offer complimentary frame adjustments; we are not responsible should the frame break during adjustment. We will gladly reuse your previous frame if it is suitable for new lenses. The optician will inspect the frame and has the right to decline reuse of the frame.

Collections on Past Due Accounts -
If your account becomes past due, we will try to collect this debt by sending out invoices or setting up a payment plan. If all other attempts fail, your account may be referred to a collections agency as a last resort. If this action is required, you agree to pay any collection costs, court costs and reasonable attorney fees.

Patient's Name _____

Signature of Patient or Guardian _____ Date:_____