Welcome to Meridian Family Eyecare

Dan C. Thieme, O.D.

Today's Date: _____

PLEASE FILL OUT ALL FORMS COMPLETELY

Patient Information:

Last Name _____

First _____ Middle _____

Street_____

City _____ State _____ Zip _____

Home phone _____Work phone _____

Cell phone _____ Social Sec # XXX-XX- _ _ _ _

Email_____

Male / Female Birth date _____Age _____

Single / Married / Divorced / Widowed

Employer (or school) _____

Occupation (or grade) _____

Hobbies / Interests _____

<u>Parent/Guardian OR Primary member on the Insurance</u> (required for all children under 18):

Relationship to patient _____

Last Name_____

First _____ Middle _____

Street_____

City _____ State _____ Zip _____

Email_____

Home phone _____Work phone _____

Cell phone _____

Male / Female Birth date _____Age _____

Single / Married / Divorced / Widowed

Employer _____

Occupation _____

Social Sec # XXX-XX- _ _ _ _

Primary Medical Physician_____ Address_____

Vision Insurance _____ Primary Health Insurance _____

Secondary Insurance _____ **Please present insurance cards.**

Insurance Policy and Financial Agreement:
We are happy to assist you in determining the benefits of your individual insurance policy, and in collecting your reimbursement of insurance benefits for medical and vision services. To avoid any misunderstanding, please read the following carefully:

I understand that payment is due at the time of service. This includes deductibles, co-payments, co-insurance and other non-covered charges.

I understand that my insurance will be billed as a courtesy, and that I am responsible for any and all charges not covered by my insurance. I understand that all insurance cards must be presented at the time of service. If I do not provide all my insurance cards at the time of my initial service, then this office has no responsibility to submit insurance claims on my behalf. If insurance information is not provided by me at the initial visit, any insurance filing will be my responsibility. I understand that my insurance may disallow some charges and that these amounts are my responsibility.

I understand that I am responsible for any referrals or prior authorizations required by my insurance company for payment to be made on my claims. If I do not obtain prior authorization and payment is denied by my insurance carrier because of this, all balances will be my responsibility.

I understand that I will be responsible for any attorney's fees, court costs and/or collection fees added to my account if it becomes necessary to refer my account to an outside source for collection.

I authorize the use of this form on all insurance submissions, including Medicare, and authorize release of information to all of my insurance companies. I authorize the doctor to act as my agent to help me obtain payment from my insurance companies. I authorize payment to be made directly to the provider and permit a copy of this authorization to be used in place of the original.

Consent: I hereby authorize Meridian Family Eyecare to administer diagnostic & medical procedures & treatments as necessary for proper health care.

Refund/Return Policy: No refund can be made on clinical procedures or services, including eye examination, refraction, contact lens fitting or medical office visits. Refunds for optical products, including frames, lenses, unopened boxes of contact lenses, can only be made within 30 days of receiving the product, or 45 days of our original product order. The product must be returned without damage. Opened or damaged boxes of contact lenses are not returnable. After 30 days, only 50% of the product cost may be reimbursed. After 90 days, no refund, exchange or return can be made, unless the product was part of a "year supply of contact lenses," for which we may exchange the product for updated powers at the doctor's discretion.

Signature _____ Date _____

Print name_____

Medical History Questionnaire

(Please print clearly and use the back of this page if you need more space)

Today's date:_____

Name:_____

Your age: _____

What is the main reason for your visit today?

_____

_____

How did you learn about our office?

Phone book Internet Friend/Family Location

Other_____

Would you like to wear contact lenses?

Yes Not interested at this time.

Are you interested in LASIK?

Yes Not at this time Had LASIK Previously

Do you have any of these eye symptoms?

Blurred distance vision Glare, halos around lights

Blurred reading vision Itching Burning

Double vision Eye mattering Tearing

Flashing lights Floaters Foreign body sensation

Red Eyes Dry Eye Eye Pain

Have you ever had any of these eye problems?

Cataract Serious eye injury

Glaucoma Iritis/uveitis

Macular degeneration Lazy eye

Wore eye patch as a child Retinal detachment

Other:_____

Have members of your family had any eye diseases?

(This would be your father, mother, siblings, grandparents)

Glaucoma Diabetes Diabetic eye disease

Cataract Crossed eyes Blindness Poor Vision

Macular degeneration Retinal detachment

Iritis/uveitis Other:_____

Have you ever had any of these conditions?

Stroke, High Cholesterol, High blood pressure, Arthritis Allergies, Heart disease, Diabetes, AIDS, HIV, Lung diseases, Cancer, Anemia, Thyroid disease, Headaches/Migraines, Dizziness, Other:_____

Are you pregnant or nursing?

No Yes

List your allergies: (Medical or other)

None known If Yes, which ones? (list below)

Medication/material	**What reaction did you have?**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Eye medications you currently take:

None Artificial Tears

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 6 per day
_____	_____	1 2 3 4 6 per day
_____	_____	1 2 3 4 6 per day
_____	_____	1 2 3 4 6 per day

Other medications you currently take:

None Aspirin on a daily basis

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 6 per day
_____	_____	1 2 3 4 6 per day
_____	_____	1 2 3 4 6 per day
_____	_____	1 2 3 4 6 per day
_____	_____	1 2 3 4 6 per day

Do you use?

Tobacco: Current user Former user Never

Alcohol: Current user Former user Never

Please list any eye surgeries you have had:

None

Type of Eye Surgery	Which Eye	Year
_____	Right Left	_____
_____	Right Left	_____
_____	Right Left	_____

Please list any other surgeries you have had:

None

Type of Surgery	Year
_____	_____
_____	_____
_____	_____

Name:_____ Date:_____

REVIEW OF SYSTEMS

New patients, established patients who may be having a new problem, or patients we haven't seen in a while, please complete this form. We need to update our records on your general health. In each area, if you are not having any difficulties, please check "**No Problems**." If you are **currently** experiencing any of these symptoms listed, please, **CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask a technician or the doctor.

Constitution (General Health)
No Problems, Developmental Disabilities, Cancer, Fatigue Syndrome, Other:_____

Ears, Nose, Throat
No Problems, Hearing Loss, Sinusitis, Dry Mouth, Laryngitis
Other:_____

Neurological
No Problems, Multiple Sclerosis, Epilepsy, Cerebral Palsy, Tumor, Stroke/CVA, Migraine, Autism Spectrum Disorder
Other:_____

Psychiatric (Mood & Thinking)
No Problems, Depression, Attention Deficit, Anxiety Disorder, Bipolar Disorder, Other:_____

Cardiovascular
No Problems, Hypertension, Stroke/CVA, Heart Disease, Vascular Disease, Congestive Heart Failure
Other:_____

Respiratory
No Problems, Cigarette Smoker, Asthma, Bronchitis, Emphysema, Chronic Obstruction, Sleep Apnea
Other:_____

GI (Stomach & Intestines)
No Problems, Crohn's, Colitis, Ulcer, Acid Reflux, Celiac Disease
Other:_____

GU (Kidney & Bladder)
No Problems, Kidney disease, Prostate disease/cancer, STD, Herpes, Chlamydia, Benign Prostate Hypertrophy, Pregnant/Nursing
Other:_____

MS (Muscles, Bones, Joints)
No Problems, Arthritis, Osteoarthritis, Fibromyalgia, Muscular Dystrophy, Ankylosing Spondylitis, Osteoporosis, Gout
Other:_____

Integ. (Skin, Hair, Breast)
No Problems, Eczema, Rosacea, Psoriasis, Herpes Simplex/Cold Sores, Herpes Zoster/Shingles
Other:_____

Endocrine
No Problems, Type 2 Diabetes Mellitus, Type 1 Diabetes Mellitus, Thyroid dysfunction, Hormonal dysfunction
Other:_____

Hematologic (Blood/Lymph)
No Problems, Anemia, Large-volume blood loss, Ulcer, Hypercholesteremia, Other:_____

Allergy/Immunologic
No Problems, Drug Allergies, Environmental Allergies, Rheumatoid Arthritis, Lupus, Sjogren's Syndrome
Other:_____

Meridian Family Eyecare

DISCLOSURE OF PROTECTED HEALTH INFORMATION

I acknowledge that I have been offered a copy of Meridian Family Eyecare's notice of Privacy Practices.

_____ _____

PATIENT or GUARDIAN SIGNATURE DATE

I hereby authorize the following people to be made aware of my test results, appointment times, medical information and patient account status. I understand that if someone inquires about any of the information listed above and is NOT listed on this consent form, information may not be released. We must have a signature authorizing release of any medical information.

_____ _____

NAME/RELATIONSHIP TO PATIENT NAME/RELATIONSHIP TO PATIENT

_____ _____

NAME/RELATIONSHIP TO PATIENT NAME/RELATIONSHIP TO PATIENT

AUTHORIZATION

I authorize Meridian Family Eyecare to release any medical information pertaining to my care to my referring physician, any physician I am referred to from this office, and any other physician/office participating in my care. I authorize treatment from this office and payment of medical benefits to the physician/supplier for those services rendered not to exceed the total billed charges for those services. I authorize the release of any information necessary to process insurance claims and I certify the information contained herein is correct. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to medical assignment of benefits apply.

_____ _____

PATIENT or GUARDIAN SIGNATURE DATE

_____

PATIENT or GUARDIAN NAME (PLEASE PRINT)

For Office Use Only

Complete this section if this form is not signed and dated by the patient or an authorized representative of the patient.

I have made a good faith effort to obtain a written acknowledgement of receipt of the notice of Privacy Practices for Meridian Family Eyecare, but was unable to do so for the following reasons:

☐ Patient or authorized representative refuses to sign

☐ Patient is unable to sign

☐ Other: _____

Employee Name _____ Employee Signature _____ Date _____