Eden Prairie Eye Care

Patient Information:

Last Name: _____ **First Name:** _____ **M.I.** _____ **M F**

Address: _____ **Date of Birth:** ____/____/_____

City: _____ **State**_____ **Zip:** _____ **Occupation:**_____

Social Security Number: _____ **Email Address:** _____

Preferred Phone: Type: _____ **( )**_____ **Other Phone: ( )**_____

Do we have permission to contact you for appointment reminders? ❑ Yes ❑ No

For promotions? ❑ Yes ❑ No Preferred Contact Method: ❑ Phone ❑Mail ❑Email ❑ Any

Whom may we thank for referring you to our office? _____

HIPPA Privacy Acknowledgement (Brochure Available Upon Request):

- I authorize Eden Prairie Eye Care to release any medical information to providers involved in my treatment.
- I acknowledge that I have been given the opportunity to read and/or receive Eden Prairie Eye Care's Notice of Privacy Practices and this authorization will remain in effect until revoked by me in writing.
- The following listed person(s) have my permission to discuss health and financial information on my behalf (optional) _____

X PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

Medical and Vision Insurance Plan Policies:

- I understand that Eden Prairie Eye Care is happy to file claims to my medical/vision insurance plan(s) as a service to me. In the event that my plan determines that I am not eligible for coverage at the time of service, by signing this statement below I hereby agree to be financially responsible for charges not covered by my plan.
- By signing below I am requesting payment of authorized insurance benefits be made to Eden Prairie Eye Care for services furnished to me by any optometrist providing care at this clinic.

X PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

Private-Pay Patients:

- I have chosen the private-pay option and decline insurance submission. I understand that payment is due for all services rendered on the date of service.

X PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

Optomap Digital Retinal Imaging:

By selecting and option and signing below you are acknowledging that you have read the attached document explaining your options for the evaluation of the internal health of your eyes.

____ Optomap Digital Retinal Examination

____ Dilated Retinal Examination

____ Informed Refusal of both options. I have been informed by my optometrist of the need for Optomap Retinal Imaging or dilation of my eyes and hereby decline both.

X PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

Contact Lens Wearers:

Eden Prairie Eye Care charges $55.00 for standard contact lens evaluations and $68.00 for all rigid gas permeable or new multifocal/mono vision contact lens fittings. Any follow up visits and trial contact lenses required for the fitting process will be included in this fee. Please tell us a little about your contact lenses below:

Have you ever worn contact lenses? ❑ Yes ❑ No* Do you currently wear contact lenses? ❑ Yes ❑ No If yes, which brand? _____ Current Prescription: _____

Do you sleep in your contacts? ❑ Yes ❑ No Are you interested in new contacts? ❑ Yes ❑ No

**All new contact lens wearers will be required to complete an insertion and removal class in office included in the fees mentioned above.*

MEDICAL HISTORY QUESTIONNAIRE:

Name: _____ **Date of Last Eye Exam**:____/___/_____ **Date**: ___/___/____

ESTABLISHED PATIENT'S ONLY: If there are no changes with the information below, **initial here** and skip this page: _____

Medications Currently Taken (include over-the-counter & herbals): _____

_____

Allergies to Medication: Y N **If Yes, list medications**:_____

List any Surgeries you have had:_____

Check any of the following that you currently have or have a history of: ❑ Cataract ❑ Macular Degeneration ❑ Glaucoma/suspect ❑ Retinal Hole/Detachment ❑ Strabismus/amblyopia (lazy eye) ❑ Patching ❑ Keratoconus ❑ Eye Injury ❑ **Eye Surgery**: __Cataract __PRK/LASIK __Glaucoma __Diabetic Retinopathy __ Eye Muscle __ Lid

REVIEW OF SYSTEMS: *Please circle any of the following problems you have had*

Eyes	Dry Eye Redness Tearing Eye Strain/Pain Poor Night Vision Floaters (new) Burning Discharge Light Sensitivity Night Glare Flashes of light Itching Blurred vision Headache (new?) Double/Loss of Vision
Constitution	Developmental Disabilities Cancer :Type_____ Fatigue Syndrome Other
ENT	Hearing Loss Sinusitis Dry Mouth Laryngitis Other
Neurological	Multiple Sclerosis Epilepsy Autism Cerebral Palsy Tumor Stroke Migraine
Psychiatric	Depression Attention Deficit Anxiety Disorder Bipolar Disorder Other
Cardiovascular	Hypertension Heart Disease Vascular Disease Congestive Heart Failure Other
Respiratory	Cigarette Smoker Asthma Bronchitis Emphysema COPD Sleep Apnea Other
Gastrointestinal	Crohn's Colitis Ulcer Acid Reflux Celiac Disease IBS Other
Genitourinary	Kidney Disease Prostate Cancer STD—Herpes/Chlamydia Benign Prostate Pregnant Nursing Current Only
Musculoskeletal	Osteoarthritis Arthritis Fibromyalgia Muscular Dystrophy Ankylosing Spondylitis Other Osteoporosis Gout
Integumentary	Eczema Rosacea Psoriasis Cold Sores Shingles: Location_____ Other
Endocrine	Diabetes Type 2 Diabetes Type 1 Thyroid Disorder Hormonal Dysfunction Other
Blood/Lymphatic	Anemia High Cholesterol Large Volume Blood Loss Other
Allergic/Imm	Environmental Allergies Rheumatoid Arthritis Lupus Sjogren's Syndrome HIV Other

SOCIAL HISTORY:

Does your vision limit any activities (driving, reading, sports, work, etc.)? Y N
Do you drink alcohol? Y N If yes, how much? _____
Do you smoke? Y N If yes, how much?_____

Family History	Cancer	Diabetes Type I	Diabetes Type 2	Hypertension	Hyper-thyroid	Hypo-thyroid	Cataract	Macular Degeneration	Glaucoma
Father									
Mother									
Brother									
Sister									
Child									