Eden Prairie Eye Care

Patient Information:

Name: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth:_____ Preferred Phone:_____ Occupation:_____

Email: _____ Refused **Preferred Contact Method: Email Text Phone**

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

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

Medical and Vision Insurance Plan Policies:

- I understand that filing a medical/vision insurance plan is an additional service provided by this clinic.
- 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 the optometrist providing care at this clinic.

PATIENT/GUARDIAN SIGNATURE:_____

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.

PATIENT/GUARDIAN SIGNATURE:_____

Payment Policy:

- By signing below I am acknowledging that I am responsible for payments for services rendered in the event that my insurance does not cover them. In addition, all payment not submitted to insurance is due on the date of service. In the event that it is not collected or my insurance determines a balance is my responsibility, I will be billed a maximum of three times by mail. If no response is received, a $20 collection fee will be added to my account and the balance will be forwarded to a collection agency.
- I recognize that it is my responsibility to keep Eden Prairie Eye Care up to date with my current mailing address.

PATIENT/GUARDIAN SIGNATURE:_____

HIPAA Privacy Acknowledgement (Brochure Available Upon Request):

- I authorize Eden Prairie Eye Care to share 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 is to remain in effect until revoked by me in writing.
- The following listed person(s) have my permission to discuss medical and financial information on my behalf (optional): _____
- I have the right to receive my medical information in the format that I request including in person pick up, fax, email or postal mail service. I understand that should I request that my medical information be sent by email that there is an inherent risk of this information being intercepted associated with unsecured email use.
  If you do NOT want to receive information by email please initial here ____ , otherwise by signing below you acknowledge that risk and authorize us to send information you specifically request to the email address on file.

PATIENT/GUARDIAN SIGNATURE:_____

PRINTED NAME:_____ **Today's Date:**_____

COVID SCREENING:_____

Have you tested positive for COVID-19 and/or waiting test results for COVID-19?

☐ No ☐ Yes - Please contact a team member prior to continuing this paperwork.

Please select any of the following if applicable:

☐ Fever
☐ Shortness of breath/Dry cough
☐ Runny nose
☐ Sore throat
☐ Sneezing
☐ New headache, New fatigue or weakness
☐ New loss of senses including taste and smell
☐ Been in recent contact with someone that has tested positive for COVID-19

☐ **I confirm that I am not experiencing any of the above symptoms**

Signature: _____ **Date:** _____

Retinal Evaluation:_____

As part of your comprehensive eye examination, the doctors at **Eden Prairie Eye Care** recommend a set of diagnostic procedures called **Optomap Digital Retinal Imaging with iWellness Ocular Health Screening**. These specialized procedures are ultra wide digital images and scans of the sensitive tissues in the retina. Together they aid in early detection of ocular conditions such as glaucoma, macular degeneration, diabetes and even some cancers. They often do not require additional dilating drops that cause blurred vision and light sensitivity after your eye exam and help reduce the time spent in the office during your appointment. This permanent health record is invaluable in assessing even the smallest change in the structures of your eyes year over year. In the event that your insurance does not cover this service (most plans do not) there will be an additional copay due on the date of your appointment.

☐ **I have read the above statement and agree to the required $39 copay for this service. OR**

I understand that the doctors at **Eden Prairie Eye Care** recommend dilation to evaluate the internal health of my eyes if I refuse **Optomap Digital Retinal Imaging with iWellness Ocular Health Screening**. These drops will cause blurry vision and light sensitivity after my appointment that can last up to 6 hours and in some cases longer.

☐ **I have read the above statement and agree to have a dilated exam at my appointment.**

PATIENT/GUARDIAN SIGNATURE:_____

Contact Lens Wearers:_____

- The cost for contact lens evaluations is between **$59.00 and $79.00.** Any follow up visits and trial contact lenses required for this process will be included in this fee within the 90 day fit period.
- All new contact lens wearers will be required to complete a contact lens insertion and removal class in office and are charged an additional fee of **$25.00.**
- **New Patients:** Please tell us about your lenses here: **Do you sleep in your lenses?** ☐ **Yes** ☐ **No**

- **Brand:**_____ **Prescription: RT:**_____ **LT:**_____
  I have read these statements and wish to proceed with a contact lens evaluation during today's visit:

PATIENT/GUARDIAN SIGNATURE:_____

PRINTED NAME:_____ **Today's Date:**_____

Medical History Questionnaire:_____

Name:_____ Date of Last Eye Exam:_____ **Today's Date:**_____

What is the primary reason for your visit today? _____

Medications (if name is unknown list what they are taken for): _____

_____

_____ ☐ No Current Medications

Allergies to Medications: ☐No ☐Yes list here: _____

Surgeries (non ocular): _____

Check any of the following applicable personal ocular conditions: ☐ Eye Injury ☐Cataract☐Keratoconus ☐Macular Degeneration ☐Glaucoma/Suspect ☐Retinal Hole/Detachment ☐Strabismus/amblyopia (lazy eye)

☐ **Eye Surgeries**: ☐ Cataract ☐ PRK/LASIK ☐ Glaucoma ☐ Diabetic Retinopathy ☐ Eye Muscle ☐ Lid

Review of Systems:_____

Eyes:	☐ Dry Eye	☐ Tearing	☐ Eye Pain	☐ Night Glare
	☐ Redness	☐ Discharge	☐ Light Sensitivity	☐ Double/Loss of Vision
	☐ Burning	☐ Blurred Vision	☐ Headache (new)	☐ Floaters (new)
	☐ Itching	☐ Eyestrain	☐ Poor Night Vision	☐ Flashes of Light

Existing Patients Only: If there are no changes with the information below initial _____ and skip this page

General	☐ Developmental Disabilities ☐ Fatigue Syndrome ☐ Cancer Type:_____ ☐ Other:	**Psych**	☐ Depression ☐ Attention Deficit ☐ Anxiety Disorder ☐ Bipolar Disorder ☐ Other:	**Gastro-Intestinal**	☐ Crohn's ☐ Colitis ☐ Ulcer ☐ Acid Reflux ☐ Celiac Disease ☐ IBS ☐ Other:	**Skin**	☐ Eczema ☐ Rosacea ☐ Psoriasis ☐ Cold Sores ☐ Shingles Location:_____ ☐ Other:
Ear Nose Throat	☐ Hearing Loss ☐ Sinusitis ☐ Dry Mouth ☐ Laryngitis ☐ Other:	**Cardio-Vascular**	☐ Hypertension ☐ Stroke/CVA ☐ Heart Disease ☐ Vascular Disease ☐ Congestive Heart Failure ☐ Other:	**Gastro-Urinary**	☐ Kidney Disease ☐ Prostate Cancer ☐ Herpes ☐ Chlamydia ☐ Benign Prostate ☐ Currently Pregnant ☐ Currently Nursing ☐ Other:	**Endocrine**	☐ Diabetes Type 2 ☐ Diabetes Type 1 ☐ Thyroid Disorder ☐ Hormonal Dysfunction ☐ Other:
Neuro	☐ Multiple Sclerosis ☐ Epilepsy ☐ Cerebral Palsy ☐ Tumor ☐ Stroke/CVA ☐ Migraine ☐ Autism ☐ Other:	**Lungs**	☐ Tobacco Use ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ COPD ☐ Sleep Apnea ☐ Other:	**Musculo-Skeletal**	☐ Osteoarthritis ☐ Arthritis ☐ Fibromyalgia ☐ Muscular Dystrophy ☐ Ankylosing Spondylitis ☐ Osteoporosis ☐ Gout ☐ Other:	**Blood Lymphatic**	☐ Anemia ☐ High Cholesterol ☐ Large Volume ☐ Blood Loss ☐ Other:

Allergic Immune	☐ Environmental Allergies ☐ Rheumatoid Arthritis	☐ Lupus ☐ Sjogren's Syndrome	☐ HIV ☐ Other:

Social History:_____

Does your vision limit any activities (driving, reading, sports, work, ect) ? ☐ Yes ☐ No

Do you drink alcohol?☐No ☐Yes How much? _____ Do you smoke? ☐No ☐Yes How much? ____

Family History:	Cancer	Diabetes Type 1	Diabetes Type 2	Hypertension	Thyroid Dysfunction	Cataract	Macular Degeneration	Glaucoma
Father								
Mother								
Sibling								
Child								