INFORMATION REGARDING YOUR OFFICE VISIT

Please bring completed forms, insurance cards, medication list, and previous surgery list with you to your visit.

Your visit with us may last one to two hours depending on the type of evaluation you require.

Your eyes will be dilated for the examination.

Dilating drops frequently blur vision for a length of time, which varies from person to person and may make bright lights bothersome. It is not possible for the doctor to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, you may want to arrange a driver for the day of your visit. But it is not required.

WHAT IS A REFRACTION?

A refraction is a test that is done to measure your best possible vision. During the test, lenses are placed in front of the eye and the patient is asked, "Which is better one or two?" A refraction is an essential part of an eye examination:

1. It is used to determine the correct prescription of glasses or contacts.
2. It is performed during a routine eye exam.
3. It is performed as part of the evaluation and monitoring of a medical condition such as diabetes, cataracts, glaucoma and macular degeneration.
4. It is performed during pre-operative care.
5. It is performed during post-operative care.

Although a refraction is an essential part of an eye exam, it is considered a **non-covered** service by Medicare and other medical insurances; thus becomes the responsibility of the patient to pay for the refraction portion of the examination. The charge of the refraction is $70.00.

_____ _____

Patient Signature Date

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Female | Male
Last First M.I.

Address: _____
Street City State Zip

Home Phone: ( ) _____ Cell: ( ) _____ Email: _____

Age: _____ Social Security #: _____ Race/Ethnicity: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Separated

If married, spouse's name: _____

Patient Occupation: _____ Work Phone: ( ) _____

Pharmacy/City: _____ Referring Doctor/City: _____

Emergency Contact: _____ Phone #: ( ) _____

(Primary) Medical Insurance: _____ ID: _____ Group #: _____

** (*If other than patient*) Policy Holder: _____ DOB: _____

Secondary/Supp Insurance: _____ ID: _____ Group #: _____

HIPPA APPROVED CONTACTS - (friend/family you authorize MEI to release medical info to per your request via phone, etc)

Name: _____ Relationship to Patient: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Name: _____ Relationship to Patient: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage including interest that may be charged to the account. It is customary to pay for services rendered unless other arrangements have been made in advance. INSURANCE AUTHORIZATION AND ASSIGNMENT- I hereby authorize Minnesota Eye Institute to release information to insurance carriers concerning my medical condition and treatments. I hereby assign to Minnesota Eye Institute all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance. This authorization is to remain in effect until I choose to revoke it in writing.

Signature: _____ **Signature Date:** _____

I am a patient of Minnesota Eye Institute and I hereby acknowledge receipt of Minnesota Eye Institutes Notice of Privacy Practices and HIPAA compliance policy.

Signature: _____ **Signature Date:** _____

MINNESOTA EYE INSTITUTE MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ DOB: ____/____/_____ Last Eye Exam: ____/____/_____

Primary Care Physician: _____ Referring Doctor: _____

Do you wear glasses? ☐ Yes ☐ No **Do you wear contact lenses?** ☐ Yes ☐ No

Reason for today's visit: _____

Are you <u>currently</u> experiencing any of the following: (Please mark all that apply)							
Blurry/Decreased Vision		Dry Eyes		Flashes/Floaters		Itchy Eyes/Lids	
Double Vision		Droopy lid(s)		Glare/Light Sensitivity		Red Eye(s)	
Watery Eyes		Eye Pain/Burning		Growth/Bump in Lid		Other:_____	
Past Ocular History: (Please mark all that apply)							
NONE		Cataract(s)		Diabetic Retinopathy		Dry Eyes	
Glaucoma		Macular Degeneration		Previous Eye Injuries		Previous Eye Surgeries	
Retinal Detachment		Strabismus		Other: _____			
Current & Past Medical Conditions: (Please mark all that apply)							
NONE		Anemia		Anxiety		Arthritis	
Asthma/Emphysema		Cancer(type)_____		COPD		Depression	
Diabetes		Hearing Loss		Hepatitis (A, B, or C)		High Cholesterol	
Heart Disease		HIV/AIDS		Hypertension (high blood pressure)		MRSA	
Open Wounds		Radiation Treatment		Seizures		Sjogren's	
Stroke		Thyroid Disease (hyper or hypo)		Other: _____			
Family History: (Please mark all that apply)							
Amblyopia/Strabismus (lazy eye)		Blindness		Cancer(type) _____		Diabetes	
Glaucoma		Heart Disease		Hypertension		Macular Degeneration	
Retinal Detachment		Stroke		Thyroid Disease		Other: _____	

List past surgeries and dates:

_____

_____

_____

_____

_____

List all current Medications and Dosages: (or attach list)

_____

_____

_____

_____

_____

_____

Medication Allergies: _____

Other Allergies: _____

Social History	
Do you smoke? Y N _____ Packs/day **Have you ever smoked?** Y N **Total years smoking:** _____	
Do you drink alcohol? Y N ___ glasses/bottles per day/week	**Have you had a pneumonia vaccine?** Y N

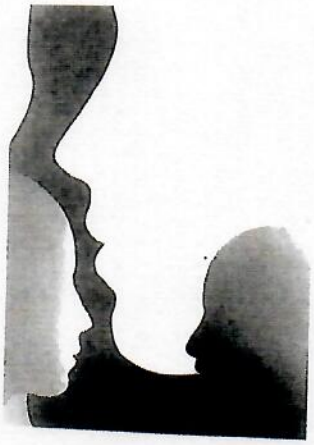
Do you currently use Flomax? _____

Have you ever used Flomax? _____

Do you have a pacemaker? _____

Do you have an internal defibrillator? _____

Patient Signature: _____ Date: _____



LEARNING YOUR VISION PERSPECTIVE

SURVEY FOR CATARACT PATIENTS

You have an important decision to make about your vision future. This survey is designed to help us understand your vision goals so we can provide you with the best possible lens for your lifestyle.

1 **Throughout the day, you perform activities that require your eyes to focus at different distances.**
Circle or write in the activities that are most important for your lifestyle:

DISTANCE

Driving Golf Live sports Scenery

Other: .....

INTERMEDIATE

Car dashboard Computer Grocery shopping Tablet

Other: .....

NEAR

Fine print Detailed hobbies Mobile phone Makeup

Other: .....

2 **What do you currently find challenging or bothersome?**
Please indicate with a check below.

- ○ Streetlights/ headlights
- ○ Reading
- ○ TV captions
- ○ Bright daylight

3 **When you think long term, would you like to rely on your glasses less?**
Please indicate with a check below.

- ○ I don't mind
- ○ It'd be nice
- ○ Glasses are annoying
- ○ I hate wearing them

4 **How often do you drive in low-light conditions (dusk, night, dawn, rain)?**
Please indicate with a check below.

- ○ Never
- ○ Not often, but I'd like to
- ○ Occasionally
- ○ Often

5 **Your doctor will discuss your options for cataract surgery during your consultation.**

How knowledgeable do you feel about advanced lenses and laser cataract technology?
Please indicate with a check below.

- ○ Not yet knowledgeable
- ○ Slightly
- ○ Somewhat
- ○ Knowledgeable

6 **To ensure your visit is a great experience, please share any questions or concerns you would like us to know about.**

7 **Please describe your personality type as best you can.**
Please indicate with a check below.

- ○ Easygoing
- ○ Organized, but flexible
- ○ Always plans ahead
- ○ Perfectionist

DRY EYE **QUESTIONNAIRE**

Patient Name or ID: _____ Date: _____

Technician: _____

Have you ever been diagnosed with Dry Eye Disease or Ocular Surface Disease?

☐ Y ☐ N When? _____

Do you have any of the following symptoms?

- ☐ Blurry vision
- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Light sensitivity
- ☐ Excess tearing/watering eyes
- ☐ Tired eyes, eye fatigue
- ☐ Stringy mucus in or around the eyes
- ☐ Foreign body sensation
- ☐ Contact lens discomfort
- ☐ Scratchy feeling of sand or grit in the eye

Have you had any of the following surgeries?

Cataract: ☐ Y ☐ N Glaucoma: ☐ Y ☐ N Refractive Surgery: ☐ Y ☐ N

Do you use?

- ☐ Contact lenses
- ☐ OTC eye drops such as artificial tears
- ☐ Rx eye drops for Dry Eye Syndrome (e.g., Restasis*)
- ☐ Rx eye drops for Glaucoma (e.g., Xalatan,* Timolol)
- ☐ Rx eye drops for Allergy (e.g., anti-inflammatory, antihistamine)
- ☐ Nutritional supplements (e.g., flaxseed oil, omega-3)

Are your symptoms related to the following environmental conditions?

- ☐ Windy conditions
- ☐ Places with low humidity (e.g., airplanes/hospital)
- ☐ Areas that are air conditioned/heated

Are you taking any of the following medications?

- ☐ Antihistamines/decongestants
- ☐ Antidepressant or anti-anxiety
- ☐ Oral corticosteroids
- ☐ Hormone replacement therapy or estrogen
- ☐ Antihypertensives (e.g. diuretic, beta-blocker)
- ☐ Accutane* or other oral treatment for acne

Have you ever had punctal occlusion? ☐ Y ☐ N

If the information provided in this form, in conjunction with other clinical data, raises the suspicion of Dry Eye Disease, then obtaining a Tear Osmolarity Test may be indicated.

I reviewed this form and based on the information contained therein and other available clinical data, I suspect that this patient has dry eye disease and obtaining a tear osmolarity measurement is medically necessary for the diagnosis and management of this patient's ocular problem(s).

Attending Clinician: _____ Date: _____

*Tradenames are the property of their respective owners.