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 currently 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:

____

____

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____

____

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: ____________________