PATIENT INFORMATION

MINNESOTA EYE INSTITUTE

Name: _____ Nickname: _____
Last First (*legal name*)

DOB: ____/____/____ Age: _____ Male | Female Race/ethnicity: _____

Mailing Address: _____
Street City State Zip

Preferred Contact #: ( ) _____ Email: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Widowed If married, spouse's name: _____

Patient Occupation: _____ (Last 4 of SS# ***only if Veteran, using VA referral***): _____

Primary Care Physician: _____ Referring Doctor/ Optometrist: _____

Pharmacy Name/ Location: _____

Emergency Contact/ relation to you: _____ Contact #: ( ) _____

Have Medicare: YES / NO Health Insurance/Supp: YES / NO Name Insurance/Supp: _____

** *We cannot accept any kind of* ***Vision*** *insurance/plans/benefits.* **

HIPAA APPROVED CONTACT
(this is a friend/family member that you authorize us to release medical information to regarding your health care)

Name: _____ Relationship to Patient: _____

Preferred # for Contact: ( ) _____

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 treatment for payment. I hereby assign to Minnesota Eye Institute all payments for medical services rendered to my dependent(s) or myself. I understand that I am responsible for any amount not covered by my insurance. This authorization remains in effect until I choose to revoke it in writing.

I am a patient of Minnesota Eye Institute and I hereby acknowledge Minnesota Eye Institute's recognition and compliance of HIPAA Privacy policies.

Patient's Signature: _____ **Signature Date:** _____

HEALTH HISTORY

MINNESOTA EYE INSTITUTE

Patient Name: _____ DOB: ____/____/_____

Last Eye Exam: ____/____/_____ 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: (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 on 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: _____	

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List any/all past surgeries with (*approximate)* dates:

_____ _____

_____ _____

_____ _____

Current Medications with Dosages: (MAY PROVIDE/ ATTACH LIST)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medication Allergies: _____

NON-medication 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 the medication Flomax? YES or NO

Have you *ever* used Flomax? YES or NO

Do you have a pacemaker? YES or NO

Do you have an internal defibrillator? YES or NO

Patient Signature: _____ Date: _____

MINNESOTA
EYE INSTITUTE

INFORMATION REGARDING YOUR OFFICE VISIT

Your visit with us may last one to two hours depending on the type of evaluation you require.
Your eyes may need to 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 and/or reading thing in close proximity more difficult. It is not possible for the doctor to predict how much your vision will be affected or exactly how long the dilation will last. Because driving may be difficult immediately after an examination, you may want to arrange a driver for the day of your visit. However, it is not required for clinic appointments.

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 also 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, as well as by MOST 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 $75.00. This amount will be billed to you only *after* it has been rejected by the given insurance.

(your signature will be acquired electronically upon check-in for your examination)

_____ _____

Patient Signature Date