EYE DOCTORS OF MADISON

An Optometric Family Practice - Michael A. Baker, O.D. and Associates

Welcome to our office! Please help us provide you with the most comprehensive care possible.

Name:_____ Today's Date: _____/_____/_____

Previous Eye Doctor _____ Primary Care Physician _____

Date of Last eye exam_____ Occupation/Prior Occupation _____

MEDICATIONS: *Please list or provide a copy of any medications (includes regular vitamins, OTC meds, and eyedrops)*

HEALTH SYSTEMS REVIEW - *Do you have a problem or difficulty with…*

Eyes	*No*	*Yes*
Blurred vision	[ ]	[ ]
Double vision	[ ]	[ ]
Dry eyes	[ ]	[ ]
Mucus/discharge	[ ]	[ ]
Itchy eyes	[ ]	[ ]
Flashing lights	[ ]	[ ]
New floating spots	[ ]	[ ]
Eye strain/fatigue	[ ]	[ ]
Eye surgeries	[ ]	[ ]
Eye diseases	[ ]	[ ]
OTHER:		
General Health		
Recent fever/flu	[ ]	[ ]
Chronic fatigue	[ ]	[ ]
Weight loss/gain	[ ]	[ ]
Genitourinary		
Bladder Problems	[ ]	[ ]
Kidney Problems	[ ]	[ ]
Kidney Dialysis	[ ]	[ ]
Prostate Cancer	[ ]	[ ]

Gastrointestinal	*No*	*Yes*
Acid reflux/GERD	[ ]	[ ]
Stomach ulcers	[ ]	[ ]
Crohn's or Colitis	[ ]	[ ]
Endocrine		
Diabetes/Sugar	[ ]	[ ]
Type 1 or Type 2		
Thyroid	[ ]	[ ]
Ear, Nose, Throat		
Tinnitus (ear ringing)	[ ]	[ ]
Dry throat/mouth	[ ]	[ ]
Sinus problems	[ ]	[ ]
Allergy/Autoimmune		
Medication allergy	[ ]	[ ]
Seasonal allergies	[ ]	[ ]
Cancer	[ ]	[ ]
Lupus (SLE)	[ ]	[ ]
Rheum. Arthritis	[ ]	[ ]
Integumentary/Skin		
Eczema	[ ]	[ ]
Psoriasis	[ ]	[ ]
Rosacea	[ ]	[ ]

Cardiovascular	*No*	*Yes*
Blood pressure	[ ]	[ ]
Cholesterol	[ ]	[ ]
Heart disease	[ ]	[ ]
Stroke/CVA	[ ]	[ ]
Musculoskeletal		
Fibromyalgia	[ ]	[ ]
Osteo-Arthritis	[ ]	[ ]
Ankylosing Spond.	[ ]	[ ]
Respiratory		
Asthma	[ ]	[ ]
COPD	[ ]	[ ]
Emphysema	[ ]	[ ]
Hemtologic/Lymphatic		
Anemia	[ ]	[ ]
Bleeding/Clotting	[ ]	[ ]
Leukemia/lymphom	[ ]	[ ]
Neurologic		
Headaches(chronic)	[ ]	[ ]
Migraines	[ ]	[ ]
Alzheimer's	[ ]	[ ]
Seizure	[ ]	[ ]

FAMILY EYE HISTORY

	No	*Yes*
Blindness	[ ]	[ ]
Glaucoma	[ ]	[ ]
Macular Degen.	[ ]	[ ]
Crossed/lazy eye	[ ]	[ ]

FAMILY MEDICAL HISTORY

	No	*Yes*
Hypertension/BP	[ ]	[ ]
Diabetes	[ ]	[ ]
Cancer	[ ]	[ ]
Heart Disease	[ ]	[ ]

YOUR SOCIAL HISTORY

Do you drive a vehicle? [ ]no [ ]yes

Do you use tobacco? [ ]no [ ]yes

If no, have you ever been a smoker?

Do you drink alcohol? [ ]no [ ]yes

Active contagious condition? [ ]no [ ]yes

Thank you for taking the time to complete this long, but important survey. Your care will be customized.

Please see the second page of our preliminary paperwork for our policies signature page

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Disclosures, Disclaimers, Policies and Procedures - Signature Page

Please initial each section and sign below, indicating acknowledgement of:

_____ ***(1) Acknowledgement of Privacy Practices***
Initial

I have been given the opportunity to review a copy of this office's privacy practices. This standard government policy, often referred to as HIPAA, is posted on the office reception room wall and available on our website. Paper copies will be provided upon request.

_____ ***(2) Release and Receipt of Information***
Initial

I authorize the doctor and office to release any information required to process an insurance claim or specialty referral. I also consent to receive information, such as appointment notifications and prescription copies, via electronic means including email and patient portal access.

_____ ***(3) Insurance Financial Policy***
Initial

There are two types of health insurance that may help pay for your eye care services and products. You may have both and our practice often accepts both.

1. Vision care plans (such as VSP and EyeMed)
2. Medical insurance (such as Anthem, Medicare, and many others)

• Vision care plans cover routine eye wellness exams. These individuals do not have any medical eye problems or there are no symptoms except for a change in vision that can be corrected with contact lenses or eyeglasses. These plans do not cover diagnosis, management or treatment of eye diseases or symptoms. They do often contribute towards eyeglasses and contact lenses.

• Medical insurance must be used if you have any eye health problem or systemic health condition that can have eye complications. Examples of medical conditions or diagnoses that warrant your visit to be submitted to medical insurances include, but not limited to, headaches, diabetes, eye irritation, dry eye, allergies, floaters, glaucoma, cataracts, and macular degeneration. Your vision care plan will not cover evaluation or management of these conditions.

• If you have both types of insurance plans we may bill some services to one plan and other services to the other. If your plan allows it, we will coordinate benefits to do this ethically and legally.

I understand the differences between vision plans and medical insurance as described above. I further accept full responsibility of any fees incurred for services provided that are not covered by my insurance company(s)

_____ ***(4) Office Financial Policy***
Initial

Payment is due for services rendered same day, including insurance co-payments and unmet deductibles. Professional fees, such as exam fees or contact lens evaluation fees, are not refundable. If ordering materials (eyeglasses or contacts), payment in full is required before ordering materials. Prescription eyeglass lenses are custom made devices made for you and only you. Such individualized items are exclusive to each patient, and as such, cannot be returned, repurposed, or refunded.

_____ ***(5) Prescription Materials Policy***
Initial

We are an independent eyecare practice and may obtain your prescription lens materials from various sources. Our office promises to provide an equivalent or better product than vision plan-preferred and owned optical laboratories while ensuring you receive all entitled coverage options and discounts.

Every pair of eyeglasses purchased from our office includes our professional service for refit and repair for as long as you own your glasses - a lifetime pledge. All frames include a two year warranty against manufacturer defects. All anti-reflective lenses include a one-time, two year warranty against scratches from normal use. If you experience any difficulties, we're happily here to troubleshoot and correct any issues. We want you to love your eyeglasses!

Patient Name (Printed) _____

Patient Signature _____ **Date:** _____

Parent/Guardian Signature (if patient is a minor) _____ **Date:** _____

***if minor's parents are divorced, liability is assigned to the above signed parent*