# 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:_____ Date of Birth: _____/_____/_____ Today's Date: _____/_____/_____

Address:_____ Age:_____ Gender:_____ Primary Phone:_____

City: _____ SSN (last four)_____ Alternate Phone:_____

Insurance Policy Holder (Guarantor): _____ Your Occupation:_____

How did you hear about our office?_____ Your Employer:_____

Do you currently: [ ] need and/or wear eyeglasses [ ] wear contacts [ ] have interest in wearing contacts

Previous Eye Doctor _____ Primary Care Physician _____

Date of Last eye exam_____ Date of Last Physical_____

**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 | [ ] | [ ] |
| Gritty feeling | [ ] | [ ] |
| Itchy eyes | [ ] | [ ] |
| Flashing lights | [ ] | [ ] |
| Floating spots | [ ] | [ ] |
| Tired eyes | [ ] | [ ] |
| Eye strain/fatigue | [ ] | [ ] |
| Eye surgeries | [ ] | [ ] |
| Eye diseases | [ ] | [ ] |
| **General Health** | | |
| Recent fever/flu | [ ] | [ ] |
| Chronic fatigue | [ ] | [ ] |
| Weight loss/gain | [ ] | [ ] |
| **Gastrointestinal** | | |
| Acid reflux | [ ] | [ ] |
| Crohn's or Colitis | [ ] | [ ] |
| Stomach ulcers | [ ] | [ ] |

| **Integumentary/Skin** | *No* | *Yes* |
|---|---|---|
| Eczema | [ ] | [ ] |
| Psoriasis | [ ] | [ ] |
| **Neurologic** | | |
| Anxiety | [ ] | [ ] |
| Headaches(chronic) | [ ] | [ ] |
| Migraines | [ ] | [ ] |
| Multiple Sclerosis | [ ] | [ ] |
| Seizure | [ ] | [ ] |
| **Endocrine** | | |
| Diabetes/Sugar | [ ] | [ ] |
| *Insulin or Non-Insulin* | | |
| Thyroid | [ ] | [ ] |
| **Respiratory** | | |
| Asthma | [ ] | [ ] |
| COPD | [ ] | [ ] |
| Emphysema | [ ] | [ ] |
| **Cardiovascular** | | |
| Blood pressure | [ ] | [ ] |
| Cholesterol | [ ] | [ ] |
| Heart disease | [ ] | [ ] |
| Stroke/CVA | [ ] | [ ] |

| **Ear, Nose, Throat** | *No* | *Yes* |
|---|---|---|
| Chronic cough | [ ] | [ ] |
| Dry throat/mouth | [ ] | [ ] |
| Sinus problems | [ ] | [ ] |
| **Allergic** | | |
| Medication allergy | [ ] | [ ] |
| Seasonal allergies | [ ] | [ ] |
| **Immune/Autoimmune** | | |
| Cancer | [ ] | [ ] |
| Lupus (SLE) | [ ] | [ ] |
| Rheum. Arthritis | [ ] | [ ] |
| **Blood/Lymphatic** | | |
| Anemia | [ ] | [ ] |
| Bleeding/Clotting | [ ] | [ ] |
| Leukemia | [ ] | [ ] |
| **Musculoskeletal** | | |
| Fibromyalgia | [ ] | [ ] |
| Osteo-Arthritis | [ ] | [ ] |
| Ankylosing Spond. | [ ] | [ ] |
| **Genitourinary** | | |
| Bladder Problems | [ ] | [ ] |
| Kidney Problems | [ ] | [ ] |

**FAMILY EYE HISTORY**

| | *No* | *Yes* | *Who?* |
|---|---|---|---|
| Blindness | [ ] | [ ] | |
| Cataracts | [ ] | [ ] | |
| Macular Degen. | [ ] | [ ] | |
| Glaucoma | [ ] | [ ] | |
| Retinal Detach | [ ] | [ ] | |
| Crossed/Lazy eye | [ ] | [ ] | |

**FAMILY MEDICAL HISTORY**

| | *No* | *Yes* | *Who?* |
|---|---|---|---|
| Cancer | [ ] | [ ] | |
| Diabetes | [ ] | [ ] | |
| Heart Disease | [ ] | [ ] | |
| Kidney Disease | [ ] | [ ] | |
| Thyroid Disease | [ ] | [ ] | |
| Multiple Sclerosis | [ ] | [ ] | |

**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 |
| Illicit drug use? | [ ]no | [ ]yes |
| Active contagious disease? | [ ]no | [ ]yes |
| Pregnant or nursing? | [ ]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 disclosure and disclaimers signatures page*

# EYE DOCTORS OF MADISON

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## *Disclosures, Disclaimers, Policies and Procedures - Signature Page*

With my signature below, I acknowledge that:

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

*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 of Information***

*I authorize the doctor and office to release any information required to process an insurance claim or specialty referral.*

***(3) Insurance Financial Policy***

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, Aetna, and Medicare)

• Vision care plans only cover routine vision wellness exams, or general screening for eye disease, in individuals without specific problems or symptoms. They do not cover diagnosis, management or treatment of eye diseases. They do, however, often contribute towards eyeglasses and contact lenses.

• Medical insurance must be used if you have any eye health problem or systemic health problem that has, or can have, eye complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history. A vision plan will deny a medical claim based on the diagnosis of your specific problem.

• If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will coordinate benefits to do this properly and to minimize your out-of-pocket expense as much as possible.

Our office is happy to file your insurance claims to your medical and/or vision plan on your behalf. We will do all we can to help determine plan coverage and eligibility in advance of your visit, but this information may not always be made known. Ultimately, insurance coverage is a contract between the you as the policyholder and your insurance company, and responsibility of coverage is that of the individual.

*I further accept full responsibility of any fees incurred for services provided that are not covered by my insurance company, both predicted and unpredicted. It will be my responsibility to collect insurance reimbursement if my vision or medical plan does not list this office as preferred providers, and I will pay for services as rendered.*

***(4) Office Financial Policy***

*Payment is due for services rendered same day, including insurance co-payments. 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 receipt of all items. 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***

*Every pair of eyeglasses purchased from our office includes our professional service for refit and repair for as long as you own your glasses. All frames include a two year warranty against manufacturer defects. All anti-reflective lenses include a 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*