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	[ ]	[ ]
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*	*Who?*
Blindness	[ ]	[ ]	
Glaucoma	[ ]	[ ]	
Macular Degen.	[ ]	[ ]	
Crossed/lazy eye	[ ]	[ ]	

FAMILY MEDICAL HISTORY

	No	*Yes*	*Who?*
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 conditio [ ]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

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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 and Receipt of Information

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

(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 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

We are an independent eyecare practice and may source your prescription lens materials from various sources. Our office promises to provide an equivalent or better product than vision insurance-preferred 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. 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*