MAUMEE CENTER FOR EYECARE
1657 HOLLAND RD. SUITE D.
MAUMEE, OH 43537
419-891-1023
FAX 419-891-1138

General Information **Date:**_____

Last Name_____ First Name_____ M____ DOB:___/___/___

M or F SSN:____/____/_____ Marital Status: Married / Single / Divorced / Widowed

Address:_____ City:_____ State:_____ Zip:_____

Home Ph: ( )_____ Work Ph: ( )_____ Cell Ph: ( )_____

Employer:_____ Occupation:_____

Email Address:_____

Emergency Contact:_____ Relation:_____ Phone # ( )_____

Reason for Visit:

Date of Last Medical Exam:____/_____/_____ Primary Physician/Clinic:_____

Address:_____ Phone:_____

Date of Last Eye Exam:____/____/____ Eye Doctor's Name:_____

Do you wear glasses? Yes/ No/ All the time/ Sometimes/ Work Only/ Reading Only/ Driving Only

How old are your present glasses?_____ Do you wear prescription sun wear? Yes No

Are you interested in contacts? Yes No Do you wear contacts? Yes No Type:_____

Solution used:_____ Wearing Schedule: **Daily** **Overnight**

Replacement Schedule: **Daily** **2 week** **Monthly** **Yearly** Are you interested in Lasik? Yes No

Have you had eye injuries? Yes No Which eye?_____

Have you ever had eye surgeries? Yes No Why?_____

Have you used eye medication? Yes No Why?_____

Are you currently pregnant or nursing? Yes No N/A

Have you ever been diagnosed with ?

Cataracts: Yes/ No When were you diagnosed?_____

Glaucoma: Yes/ No When were you diagnosed?_____

Macular Degeneration: Yes/ No When were you diagnosed?_____

What are your visual symptoms? Please circle ANY that apply: Indicate RIGHT, LEFT, or BOTH.

Blurred Vision/Distance	R L B	Dry Eyes	R L B	Headaches	R L B
Blurred Vision/Near	R L B	Red Eyes	R L B	Migraines	R L B
Double Vision	R L B	Watery Eyes	R L B	Loss of Vision	R L B
Eye Strain	R L B	Wandering Eye	R L B	Crossed Eyes	R L B
Eye Infections	R L B	Mucus Discharge	R L B	Light Sensitive	R L B
Eye pain/soreness	R L B	Floaters or Spots	R L B	Sandy/Gritty Feeling	R L B
Tired Eyes	R L B	See Flashes	R L B	Poor Color Vision	R L B
Burning Eyes	R L B	See Halos	R L B	Droopy Lid	R L B
Itchy Eyes	R L B	Poor Night Vision	R L B		

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS): PLEASE CHECK IS ANY OF THE FOLLOWING APPLIES TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS **PLEASE CHECK NONE.**

Cardiovascular: ___None ___Hypertension ___Stroke ___Heart Disease ___Vascular Disease ___Other:	Endocrine: ___None ___Non-Insulin Dependent Diabetes ___Insulin Dependent Diabetes ___Thyroid Problem ___Hormonal Dysfunction ___Other:	Respiratory: ___None ___Asthma ___Bronchitis ___Emphysema ___COPD ___Other:
Constitutional: ___None ___Cancer ___Trauma/Large Volume Blood Loss ___Developmental Disability ___Other:	Ocular ___None ___Glaucoma ___Macular Degeneration ___Detached Retina ___Other:	Psychiatric: ___None ___ADHD ___Depression ___Schizophrenia ___Other:
Neurological ___None ___Multiple Sclerosis ___Epilepsy ___Cerebral Palsy ___Tumor ___Other:	Musculoskeletal: ___None ___Osteoarthritis ___Fibromyalgia ___Muscular Dystrophy ___Ankylosing Spondylitis ___Other:	Immunologic: ___None ___AIDS or HIV ___Rheumatoid Arthritis ___Lupus ___Neurofibromatosis ___Other:
Hematological: ___None ___Anemia ___Leukemia ___Other:	Gastrointestinal ___None ___Crohn's ___Colitis ___Other:	Ear/Nose/Throat: ___None ___Hearing Loss ___Upper Respiratory Infection ___Other:
Dermatologic: ___None ___Eczema ___Rosacea ___Psoriasis ___Other:	Allergies (please list) ___None Drug: Environmental:	Alcohol Use: Y N Amount: Tobacco Use: Y N Amount:

Please list any medications and/or drugs that you are taking (including herbal):

1_____For_____ 6_____For_____

2_____For_____ 7_____For_____

3_____For_____ 8_____For_____

4_____For_____ 9_____For_____

5_____For_____ 10_____For_____

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnosed with:

DISEASE/CONDITION

Retinal Detachment: Yes/No_____
High Blood Pressure: Yes/No_____
Diabetes: Yes/No_____
Cancer: Yes/No_____
Heart Disease: Yes/No_____
Thyroid Disease: Yes/No_____

Blindness: Yes/No_____
Cataracts: Yes/No_____
Glaucoma: Yes/No_____
Crossed Eyes: Yes/No_____
Macular Degeneration: Yes/No_____
Lupus: Yes/No_____

How did you hear about us?_____

Reviewed by:
Dr._____Date_____

Please visit our website at: www.maumeecenterforeyecare.com

MAUMEE CENTER FOR EYECARE

PATIENT FINANCIAL INFORMATION SHEET

Name of Patient:_____**DOB**_____

Name of Insured:_____ **DOB**_____

Name of Medical Insurance Carrier:_____

ID#_____**Group#**_____

Authorization and Release:

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of patient or parent if minor Date

HIPAA PRIVACY PRACTICE ACKNOWLEDGEMENT

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other healthcare practitioners.

I accept release of records:

_____ _____

Signature **Date**

I decline release of records:

_____ _____

Signature **Date**

Office Policy
Maumee Center for EyeCare

New patients and current patients:

Thank you for choosing us as your vision care provider. We are committed to your treatment being successful. Please understand that payment of services is considered a part of your treatment. This letter is to help us, as well as our patients understand our office and financial policies which we require you to read and sign prior to any future treatment. In order for us to keep our fees lower we need to obtain control of very costly monthly billing.

All patients must complete our Information and Insurance form before seeing the doctor.

Full payment is due at time of service unless otherwise arranged prior. We accept cash, checks, Visa, MasterCard & Discover.

Invoices are due upon receipt. If your account must be sent for collection activity, you may be asked to seek vision care elsewhere. In the event you are sent to collections we reserve the right to charge you the collection fee.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. They vary from one insurance company to another.

Minor Patients:

The adult accompanying a minor is responsible for full payment. We cannot do third party billing. If this is a divorce or custody situation we will bill the adult accompanying the minor. We no longer bill the non-present adult this is your responsibility.

Contact Lens Return Policy:

Unopened contact lenses must be returned within 30 days of purchase for credit.

Missed Appointments:

Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments. There are patients that would be willing to take the appointments at short notice. It is very costly for the doctor and staff to have wasted down time without patients. If more than one appointment is missed we may not reschedule.

I have read the office policy. I understand and agree to this new policy:

X_____ **Date:**_____

Thank you!