

MAUMEE CENTER FOR EYECARE ADULT HISTORY FORM

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: <input type="checkbox"/> None <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Disease <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Other:	Endocrine: <input type="checkbox"/> None <input type="checkbox"/> Non-Insulin Dependent Diabetes <input type="checkbox"/> Insulin Dependent Diabetes <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Other:	Respiratory: <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Other:
Constitutional: <input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Trauma/Large Volume Blood Loss <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Other:	Ocular <input type="checkbox"/> None <input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Detached Retina <input type="checkbox"/> Other:	Psychiatric: <input type="checkbox"/> None <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:
Neurological <input type="checkbox"/> None <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Tumor <input type="checkbox"/> Other:	Musculoskeletal: <input type="checkbox"/> None <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Other:	Immunologic: <input type="checkbox"/> None <input type="checkbox"/> AIDS or HIV <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Neurofibromatosis <input type="checkbox"/> Other:
Hematological: <input type="checkbox"/> None <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other:	Gastrointestinal <input type="checkbox"/> None <input type="checkbox"/> Crohn's <input type="checkbox"/> Colitis <input type="checkbox"/> Other:	Ear/Nose/Throat: <input type="checkbox"/> None <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Other:
Dermatologic: <input type="checkbox"/> None <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other:	Allergies (please list) <input type="checkbox"/> None Drug: Environmental:	Alcohol Use: Y N Amount: Tobacco Use: Y N Amount:

Please list physical reaction's to above allergies: _____

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

- | | |
|-------------------|--------------------|
| 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 _____	Blindness: Yes/No _____
High Blood Pressure: Yes/No _____	Cataracts: Yes/No _____
Diabetes: Yes/No _____	Glaucoma: Yes/No _____
Cancer: Yes/No _____	Crossed Eyes: Yes/No _____
Heart Disease: Yes/No _____	Macular Degeneration: Yes/No _____
Thyroid Disease: Yes/No _____	Lupus: Yes/No _____

Reviewed by:

Dr. _____ Date _____

**MAUMEE CENTER FOR EYECARE
PATIENT FINANCIAL INFORMATION SHEET**

Name of Patient: _____ **DOB** _____

Name of Insured: _____ **DOB** _____

If NO Insurance Card is Available please supply the Insurance Carrier and ID#

Name of Insurance Carrier: _____

ID# _____ **Policy#** _____

Insurance Card Copied: _____ Yes _____ No _____ No Card

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 my child or me 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
Thomas A. Cable, O.D. & Associates

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,

Thomas A. Cable, O.D.