

Burnsville Family Eye Care

1004 County Rd 42 E, Burnsville MN 55337 Phone (952) 894-1400, Fax (952) 808-2216

Patient Information

Name: _____ Date of Birth: _____
First MI Last

Home Phone: _____ Work: _____ Cell: _____

Address: _____
Street City State Zip

Last 4 digits SS#: _____ Email address _____

Employer/School _____ Occupation _____ FT / PT

Spouse/Partner _____

Please circle your preferences below

Communication Email/Mail/Phone **Language** English/Spanish/Other
Ethnicity Hispanic or Latino/Native Hawaiian other Pacific Island/Not Hispanic or Latino
Race White/Asian/Hispanic/Black or African Amer/Amer Indian or Alaska Native/Native Hawaiian or Other Island

How did you find Us?

- Walk In / Drive By An Acquaintance Recommend this clinic: _____
 Phone Book (Dex / Frontier / Yellow Book / Verizon / Not Sure)
 Internet: google / yahoo / Bing/ yellowbook.com / msn /other: _____
 Employer My Insurance Newspaper Mailer / Postcard
 Bulletin Ad I am a previous patient Professional Referral/ Dr's Name: _____
 Family Member **OTHER:**

Insurance Information

Primary Medical: _____
Secondary or Vision Ins.: _____

Policy Holder's Information

Name: _____ DOB _____
Name: _____ DOB _____

Complete if patient is under age 18 or in guardian's care

Parent/guardian's Name: _____ Relationship _____
Address: _____
Street City State Zip
Home Phone: _____ Work: _____ Cell: _____

Burnsville Family Eye Care will be happy to file your insurance claim on your behalf. **However, any benefits quoted by us or relayed from your insurance carrier(s) are only an estimation of benefits, not a guarantee of coverage. A final determination cannot be made until a claim is processed by your insurance carrier(s).** While we are willing to check for you, knowing your insurance benefits and restrictions are ultimately your responsibility. If your insurance company or policy requires a referral or prior authorization, it is **your** responsibility to make sure that this is obtained before services are provided. If services provided are not covered by your plan or are not of the contractual obligation with that carrier, the bill remains your responsibility.

Signing below acknowledges the Following:

- *This waiver shall stay in effect from the date shown below going forward until rescinded by Burnsville Family Eye Care.
*That I was Informed and offered Burnsville Family Eye Care's Notice of Privacy Practices (HIPPA)
*I authorize Burnsville Family Eye Care to release or request my medical records to or from any previous providers
*I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services

Signed _____ Print Name: _____ Date: _____

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Medical History

Date: ____/____/____

Last Name: _____ First Name: _____ DOB: ____/____/____

CASE HISTORY / REASON FOR VISIT:

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

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

Do you wear **glasses**? YES / NO All the time Occasionally Office Work Reading only Driving Only

Do you wear **contacts**? YES / NO Type: _____ Replace Schedule: _____

How many hours per day do you use a **computer**: _____

What are your **Activities/Hobbies**:

Golf Boating Hunting Gardening Other: _____

Have you ever had **eye injuries**? YES / NO Which Eye? _____

Have you ever had **eye surgeries**? YES / NO Why? _____

Have you ever taken **eye medication**? YES / NO Why? _____

Have you ever been diagnosed with?

Cataracts Glaucoma Macular Degeneration Retinal Detachment Other: _____

When were you diagnosed? _____

Please check any of the following past or present conditions that apply:

- | | | | |
|--|---------------------------------------|--|---|
| <input type="checkbox"/> Blurred Vision – Distance | <input type="checkbox"/> Burning Eyes | <input type="checkbox"/> Floaters or Spots | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Blurred Vision – Near | <input type="checkbox"/> Itchy Eyes | <input type="checkbox"/> See Flashes | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Glare | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Loss of Vision |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Red Eyes | <input type="checkbox"/> Poor Night Vision | <input type="checkbox"/> Crossed Eyes |
| <input type="checkbox"/> Light Sensitive | <input type="checkbox"/> Watery Eyes | <input type="checkbox"/> Poor Color Vision | <input type="checkbox"/> Eye Infections |

Are you currently **pregnant** or **nursing**? YES / NO

PLEASE TURN THIS FORM OVER AND COMPLETE OTHER SIDE

Personal Medical History (Review of Systems) PLEASE CHECK IF 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 <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Disease <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Other: <input type="checkbox"/> Medications:	Endocrine: _____ none <input type="checkbox"/> Non-Insulin Dependant Diabetes <input type="checkbox"/> Insulin Dependant Diabetes <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Other <input type="checkbox"/> Medications:	Respiratory: _____ none <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Other: <input type="checkbox"/> Medications:
Constitutional: _____ none <input type="checkbox"/> Cancer <input type="checkbox"/> Trauma/Large Volume Blood Loss <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Other <input type="checkbox"/> Medications:	Genitourinary: _____ none <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> STD – Herpetic/Chlamydia <input type="checkbox"/> Other <input type="checkbox"/> Medications:	Psychiatric: _____ none <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other <input type="checkbox"/> Medications:
Neurological: _____ none <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Tumor <input type="checkbox"/> Other <input type="checkbox"/> Medications:	Musculoskeletal: _____ none <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Other <input type="checkbox"/> Medications:	Immunologic: _____ none <input type="checkbox"/> AIDS or HIV <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Neurofibromatosis <input type="checkbox"/> Other <input type="checkbox"/> Medications:
Hematological _____ none <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other <input type="checkbox"/> Medications:	Gastrointestinal: _____ none <input type="checkbox"/> Crohn's <input type="checkbox"/> Colitis <input type="checkbox"/> Celiac Sprue <input type="checkbox"/> Other <input type="checkbox"/> Medications:	Ear/ Nose / Throat: _____ none <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Other <input type="checkbox"/> Medications:
Dermatologic _____ none <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other <input type="checkbox"/> Medications:	Allergies (please list) _____ none Drug: Environmental:	Alcohol Use Yes / No Amount per Week: Tobacco Use Yes / No Amount per Day:

Please list any medications and/or drugs that you are taking (including herbal) that are not listed above:

Family History: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) ever been diagnosed with:

Disease / Condition

Blindness:	Yes / No	Who? _____
Cataracts:	Yes / No	Who? _____
Glaucoma:	Yes / No	Who? _____
Crossed Eyes:	Yes / No	Who? _____
Macular Degeneration:	Yes / No	Who? _____
Retinal Detachment:	Yes / No	Who? _____
High Blood Pressure	Yes / No	Who? _____
Diabetes	Yes / No	Who? _____
Cancer:	Yes / No	Who? _____
Heart Disease	Yes / No	Who? _____
Thyroid Disease	Yes / No	Who? _____

Reviewed by:

Dr. _____

Date ____/____/____



DIGITAL RETINAL IMAGING

Burnsville Family Eye Care believes that using the best technology is crucial to maintaining good ocular health and preventing ocular diseases from going undiagnosed. As a result, we utilize Digital Retinal Imaging or Photography, which produces a high definition picture of your retina, interior blood vessels, and optic nerves. These images are vital in helping our doctors assess your risks for serious ocular disease.

- Yes, I would like to have Digital Retinal Imaging performed today (additional fee of \$39)
- No, contrary to our doctor's recommendation, I am refusing retinal photos & understand the health risks involved.
- I would like to discuss this with our doctors before deciding.

Vision Insurance vs. Medical Insurance

We often have patients that have both vision and medical insurance. They are very different in terms of the services they cover and it's important for our patients to understand those differences. Vision coverage is mainly designed to determine a prescription for glasses and is not equipped to deal with complex medical conditions and/or diagnoses and does not include a detailed examination of the retina. When a medical diagnosis or condition is present (such as high blood pressure, diabetes or eye disease) it is necessary to file the visit with your major medical carrier and the co-pays for that insurance will apply as well as any non-covered service. **Our office does not make these rules and they are defined by the insurance carriers themselves.** There is no way to know prior to the examination which type of insurance our office will be able to file for you. We make every effort to be on every major carrier for your convenience and we will file those claims for you. In the event that we do not take your major medical/vision insurance, we will provide you with an itemized receipt so that you may file with your carrier for reimbursement. If you have any questions, please let us know.

I understand the paragraph above and authorize Burnsville Family Eye Care to file my insurance.

Patient Signature

_____/_____/_____
Today's Date