PATIENT INTAKE FORM

DEMOGRAPHICS

NAME: ____________ DOB: ____________ GENDER: ____________

ADDRESS: ____________ CITY: ____________ STATE: ______ ZIP: ______

HOME PHONE: ____________ CELL PHONE: ____________

EMAIL: ____________ LAST 4 OF SSN: ____________ MARITAL STATUS ____________

PRIMARY CARE DOCTOR: ____________ OCCUPATION: ____________

HOW DID YOU HEAR ABOUT US? ____________

EMERGENCY CONTACT/PERSONAL REPRESENTATIVE

NAME: ____________ RELATIONSHIP: ____________ PHONE: ____________

- ✓ I assign all my medical benefits to Mayo Family Eye Care LLC, and authorize said assignee to release all information necessary to secure payment from my insurance company. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company, and that final determination can only be made when the claim is processed. As such, I understand that if some fees are not paid by my insurance, I am still responsible and will be billed for them. There will be a service charge for any bounced checks. To control billing costs and reduce the need to raise our fees, all co-payments, deductibles, and charges for non-covered services, as per my insurance contract, are due at the time they are rendered.
- ✓ HIPAA NOTICE OF PRIVACY POLICIES:
  I acknowledge that I have received and read MAYO FAMILY EYE CARE LLC's Notice of Privacy Practices.

SIGNATURE____________________________ DATE________________

NAME____DATE OF BIRTH__________________

MEDICAL HISTORY

DO YOU WEAR **GLASSES**? YES NO

DO YOU WEAR **CONTACT LENSES**? YES NO

ARE YOU INTERESTED IN CONTACT LENSES TODAY? YES NO

WHEN AND WHERE WAS YOUR LAST EYE EXAM? ____

CHIEF COMPLAINT: ____

____

MEDICAL CONDITIONS: ____

____

OCULAR CONDITIONS: ____

____

EYE SURGERIES/INJURIES: ____

MEDICATIONS/VITAMINS (PLEASE PROVIDE LIST IF YOU HAVE ONE). ____

____

ALLERGIES TO MEDICATION OR ENVIRONMENTAL: ____

WHAT IS YOUR **SMOKING STATUS:** NEVER FORMER CURRENT

IF APPLICABLE, ARE YOU PREGNANT AND/OR BREASTFEEDING? YES NO

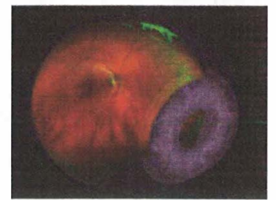
ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?

GENERAL (fatigue, fever, weakness, weight loss)	YES	NO
EARS (hearing loss, earache, discharge, ringing)	YES	NO
THROAT (soreness, swallowing, infections)	YES	NO
SKIN (rashes, itching, dryness, mole changes, sores)	YES	NO
CHEST (shortness of breath, cough, chest pain, wheezing)	YES	NO
HEART (cold extremity, murmur, ankle edema, palpitations)	YES	NO
EYES (blurry, double vision, pain, floaters, flashes)	YES	NO
NOSE (bleeding, loss of smell, sinus problem)	YES	NO
HEAD (headaches, injuries, dizziness)	YES	NO
MOUTH (loss of taste, swallowing, pain, infections)	YES	NO
GASTROINTESTINAL (abdominal pain, nausea, vomiting)	YES	NO
GENITOURINARY (incontinence, urgency, kidney stones)	YES	NO

FAMILY HISTORY

DOES ANYONE IN YOUR FAMILY HAVE THE FOLLOWING:

HIGH BLOOD PRESSURE	YES	NO	______________________
DIABETES	YES	NO	______________________
MACULAR DEGENERATION	YES	NO	______________________
GLAUCOMA	YES	NO	______________________
BLINDNESS	YES	NO	______________________



During an annual eye exam, Dr. Mayo utilizes the **optomap® ultra-widefield retinal exam** to monitor for complications including macular degeneration, diabetic retinopathy, glaucoma, and retinal holes or detachments. *These problems can develop without warning and sometimes with no signs or symptoms.*

This state-of-the-art technology also allows Dr. Mayo to see small details that can assist with detecting systemic problems unrelated to the eye such as diabetes, hypertension, cancer/tumors, auto-immune disorders, and others.

The optomap® Retinal Exam:

- ✓ Is as fast as taking a picture.
- ✓ Does not require dilating drops.
- ✓ Saved in your file enabling your doctor to make important comparisons during your annual eye exam.

The optomap® Retinal Exam is only $39.00.

____ I understand that the optomap® Retinal Exam will be performed today and do not have any questions.

Signature: ____ Date: ______________________

CONTACT LENS EXAMINATION POLICY

Contact lenses are considered medical devices that require ongoing evaluation to ensure proper care, comfort, vision, and the appropriate lens modality, design, and fitting. This service is in addition to your annual comprehensive examination and is **required in order to attain a valid contact lens prescription**. Every contact lens exam includes:

- Review of contact lens care and hygiene
- Evaluation of vision, fit, and comfort
- Evaluation of the cornea, conjunctiva and eyelid health as related to contact lens wear
- **Any progress checks within 90 days** of initial exam related to changes in contact lens prescription or material. A fee may apply to any exam after 90 days based on complexity of the exam.

Fee Schedule

Level 1: Standard evaluation with little to no changes **$45**
- This service is for established contact lens wearers who do not require a change in contact lens material, design, or a major change in prescription. This is reserved for patients that will most likely not require progress checks prior to finalizing a prescription.

Level 2: Changes made in prescription and/or lens design **$65**
- This service is for established contact lens wearers being fit in a new contact lens material, design or prescription. This type of fit may require a progress check prior to finalizing a prescription.

Level 3: New wearer or requiring a refresher course on insertion/removal **$115**
- This service includes a contact lens fitting of proper lens design and prescription, insertion and removal training, and instructions on lens care and hygiene. All progress checks during the global period are included in this fee.

Level 4: Evaluation of RGP **$100**
- This service is for evaluation of RGPs

Level 5: New fit RGP **$200**
- This service includes fitting a patient in an RGP whether they are previous or new wearers.

Exceptions to this policy are at the discretion of our office.

I have read and understand the policy above:

Sign:____Date:_______________________