



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

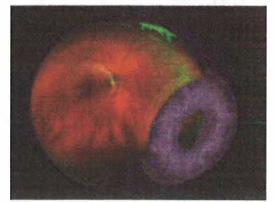
ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?

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

FAMILY HISTORY

DOES ANYONE IN YOUR FAMILY HAVE THE FOLLOWING:

- | | | | |
|----------------------|---------------------------|--------------------------|-------|
| HIGH BLOOD PRESSURE | YES <input type="radio"/> | NO <input type="radio"/> | _____ |
| DIABETES | YES <input type="radio"/> | NO <input type="radio"/> | _____ |
| MACULAR DEGENERATION | YES <input type="radio"/> | NO <input type="radio"/> | _____ |
| GLAUCOMA | YES <input type="radio"/> | NO <input type="radio"/> | _____ |
| BLINDNESS | YES <input type="radio"/> | NO <input type="radio"/> | _____ |



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 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.

	INSURANCE	OUT OF POCKET
Evaluation of contact design and prescription	\$200	UP TO \$70
New wearers with insertion and removal training	\$200	UP TO \$130

RGP evaluations and fittings are charged based on time.

Exceptions to this policy are at the discretion of our office

I have read and understand the policy above:

Sign: _____ Date: _____