MAYO FAMILY EYECARE

PATIENT INTAKE FORM

DEMOGRAPHICS

NAME: _____ DATE OF BIRTH: _____ SEX: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____ LAST 4 OF SSN: _____

MARITAL STATUS _____ PRIMARY LANGUAGE _____ RACE _____ ETHNICITY _____

PRIMARY CARE DOCTOR: _____ OCCUPATION: _____

HOW DID YOU HEAR ABOUT US? _____

INSURANCE

ROUTINE EYE INSURANCE: _____ ID NUMBER: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S DOB: _____

MEDICAL INSURANCE: _____ ID NUMBER: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S DOB: _____

RELATIONSHIP TO INSURED _____

EMERGENCY CONTACT

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. Accounts 90 days old are subject to collections, and 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.

SIGNATURE_____ DATE_____

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

IF NOT, ARE YOU INTERESTED IN CONTACT LENSES TODAY? YES NO

WHAT IS YOUR **CHIEF COMPLAINT?** _____

_____

WHAT **MEDICAL CONDITIONS** ARE YOU CURRENTLY DIAGNOSED WITH? _____

_____

WHAT **OCULAR CONDITIONS** ARE YOU CURRENTLY DIAGNOSED WITH? _____

_____

HAVE YOU EVER HAD ANY **EYE SURGERIES/INJURIES?** IF SO, EXPLAIN: _____

WHAT **MEDICATIONS AND VITAMINS** ARE YOU TAKING? (PLEASE PROVIDE LIST IF YOU HAVE ONE). _____

_____

LIST ALL DRUG AND/OR ENVIRONMENTAL **ALLERGIES:** _____

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	_____