PATIENT INTAKE FORM

DEMOGRAPHICS

NAME: _____ DO : 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?

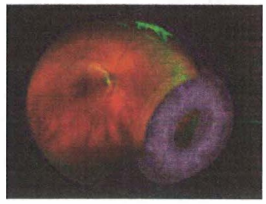
GENERAL (fatigue, fever, weakness, weight loss)	YES ○	NO ○
EARS (hearing loss, earache, discharge, ringing)	YES ○	NO ○
THROAT (soreness, swallowing, infections)	YES ○	NO ○
SKIN (rashes, itching, dryness, mole changes, sores)	YES ○	NO ○
CHEST (shortness of breath, cough, chest pain, wheezing)	YES ○	NO ○
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 ○	_____

MAYO FAMILY EYECARE



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.

Level 1: Evaluation without changes to lens design or prescription	**$45**
Level 2: Evaluation with changes to lens design or prescription	**$70**
Level 3: Evaluation and fitting with changes to lens design or prescription	**$200**
Level 4: Myopia management 6 month follow up	**$150**
Level 5: New wearers with insertion and removal training	**$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:_____