DEMOGRAPHICS & INSURANCE INFORMATION

Name _____ Date _____

Address _____ Phone _____

City _____ State_____ Zip _____ Cell Phone _____

Guardian (if applicable) _____ E-mail _____

Birthdate _____ Last Eye Exam _____

Occupation _____ Employer _____

Referred by: _____

Do you have vision insurance? □No □Yes If yes, insurance carrier _____

Do you have health insurance? □No □Yes If yes, insurance carrier _____

Do you have medicare? □No □Yes

Primary Care Physician _____ Phone Number _____

Address _____

Race: ___American Indian or Alaska Native ___Asian ___Hispanic or Latino
___Native Hawaiian or Other Pacific Islander ___White ___Black or African American

Ethnicity: ____Hispanic or Latino ____Not Hispanic or Latino _____Native Hawaiian / Other Pacific Islander

Preferred Language: ____ English ____ Spanish

Preferred Communication ___Email ____Postal ___Telephone

Assignment of Benefits

I request that payment of authorized Medicare or other assigned insurance be made directly to Hopkinton Eye Associates for any services rendered. I authorize this holder of medical information about me to release to CMS and agents and information to determine these benefits payable for related services.

I understand that I am responsible for any non-covered services.

Signature _____ Date _____
(Parent/guardian, if under age of 18)

Notice of Privacy Practices

I acknowledge that I have been offered a copy of the Notice of Privacy Practices.

Signature _____ Date _____
(Parent/guardian, if under age of 18)

Contact Lens Fees Notice

Most insurance carriers will not cover procedures related to contact lenses unless they are “medically necessary”. Most contact lenses are for cosmetic purposes. Please ask us for a quote of these additional fees.

Screening Retinal Photos

To ensure the thoroughness of your eye exam, the doctors at Hopkinton Eye Associates recommend having digital retinal photos taken on all our patients.

The procedure consists of simply taking a digital photograph of the back part of each of your eyes (retina). This is not an X-Ray or ultrasound procedure, and the camera does not touch you. You will be able to view and go over these photos with your doctor immediately after they are taken.

What parts of the eye can be seen in the photos?

The Optic Nerve, Macula, Arteries and Veins, Retina, Choroid

What diseases can be detected or monitored with dilation and photos?

Glaucoma, Macular Degeneration, Signs of Diabetes, Ocular Melanoma, Hypertension and Heart Disease, Drug induced Ocular manifestations, and many more...there are just too many to list.

Reason for this extra test:

These photos become permanent invaluable data in your record, and allow the doctors to evaluate any changes over time by comparing your baseline photos with future visits.

This screening is **NOT** covered by insurance, and requires an additional fee of $39 at the time of your visit.

You will have an opportunity to discuss this with your doctor during your exam. Please sign below to show that you have read and understood this explanation sheet.

_____ **YES**, I would like to have retinal photos taken at this time.
_____ **NO**, I would not like to have retinal photos taken at this time.

Patient Signature _____

Date _____

MEDICAL HISTORY

Name_____ Date_____

Birthdate _____/_____/_____

Emergency Contact _____ Phone Number _____

Medical History

List medications you take (including oral contraceptives, aspirin, over-the-counter medications, and home remedies)

_____

_____

Check any of the following that you have had: □ age-related macular degeneration □ inflammatory disorder

□ cataract □ strabismus □ keratoconus □ amblyopia □ glaucoma suspect □ glaucoma □ surgery

□ retinal degeneration/hole/detachment □ patching □ eye injury

Are you pregnant and/or nursing? □ No □ Yes

Do you wear glasses? □ No □ Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? □ No □ Yes If yes, what brand? _____

Type of contact lenses: □ Rigid □ Soft □ Extended Wear □ Other Are they comfortable? □ No □ Yes

Family History

Please note any family history (parents, grandparents, siblings, children: living or deceased) for the following conditions:

Disease/Condition	Yes	No	?	Relationship
Thyroid Disease	□	□	□	_____
Diabetes	□	□	□	_____
Hypertension	□	□	□	_____
Cancer	□	□	□	_____
Strabismus	□	□	□	_____
Cataract	□	□	□	_____
Glaucoma Suspect	□	□	□	_____
Amblyopia	□	□	□	_____
Severe Myopia	□	□	□	_____
Macular Degeneration	□	□	□	_____
Retinal Detachment/Disease	□	□	□	_____
Glaucoma	□	□	□	_____
Severe Hyperopia	□	□	□	_____
Other	□	□	□	_____

Social History – This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

□ Yes, I prefer to discuss my Social History information directly with the doctor.

Do you drive? □ No □ Yes If yes, do you have visual difficulty when driving? □ No □ Yes If yes, please describe:

_____

Do you use tobacco products? □ No □ Yes If yes, type/amount/how long _____

Are you a □ Former Smoker □ Current Occasional Smoker □ Current Everyday Smoker

Do you drink alcohol? □ No □ Yes If yes, type/amount/how long _____

Do you use illegal drugs? □ No □ Yes If yes, type/amount/how long _____

- OVER -

Name_____ Date _____/_____/_____

Review of Systems

Do you currently, or have you ever had, any problems in the following areas:

Eyes	**Yes**	**No**
Itching	☐	☐
Diplopia	☐	☐
Burning	☐	☐
Mattering	☐	☐
Loss of Vision	☐	☐
Photophobia	☐	☐
Red	☐	☐
Floaters	☐	☐
Loss of Sharpness	☐	☐
Flashes	☐	☐
Tearing	☐	☐
Other_____		
Constitutional		
Developmental Disorders	☐	☐
Cancer	☐	☐
Fatigue Syndrome	☐	☐
Other _____		
Ear, Nose, Mouth, Throat		
Sinusitus	☐	☐
Dry Mouth	☐	☐
Hearing Loss	☐	☐
Laryngitis	☐	☐
Other_____		
Neurological		
Epilepsy	☐	☐
Multiple Seizures	☐	☐
Tumor	☐	☐
Cerebral Palsy	☐	☐
Stroke/CVA	☐	☐
Migraine	☐	☐
Other_____		
Psychiatric		
Depression	☐	☐
Bipolar	☐	☐
Anxiety	☐	☐
Attention Deficit	☐	☐
Other _____		
Vascular/Cardiovascular		
Vascular Disease	☐	☐
Stroke	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Congestive Heart Failure	☐	☐
Other _____		
Respiratory		
Cigarette Smoker	☐	☐
Bronchitis	☐	☐
COPD	☐	☐
Emphysema	☐	☐
Asthma	☐	☐

Respiratory (continued)	Yes	No
Sleep Apnea	☐	☐
Other _____		
Gastrointestinal		
Celiac Disease	☐	☐
Crohn's Disease	☐	☐
Ulcer	☐	☐
Colitis	☐	☐
Acid Reflux	☐	☐
Other _____		
Genitourinary		
Kidney Disease	☐	☐
STD – Herpetic/Chlamydia	☐	☐
Prostate Disease/Cancer	☐	☐
Pregnant/Nursing	☐	☐
Other _____		
Musculoskeletal		
Arthritis	☐	☐
Ankylosing Spondylitis	☐	☐
Fibromyalgia	☐	☐
Muscular Dystrophy	☐	☐
Osteoarthritis	☐	☐
Gout	☐	☐
Other _____		
Integumentary		
Herpes Simplex/Cold Sores	☐	☐
Herpes Zoster/Shingles	☐	☐
Rosacea	☐	☐
Psoriasis	☐	☐
Eczema	☐	☐
Other _____		
Endocrine		
Diabetes Type II	☐	☐
Thyroid Dysfunction	☐	☐
Hormonal Dysfunction	☐	☐
Diabetes Type I	☐	☐
Other _____		
Hematologic/Lymphatic		
Large Volume Blood Loss	☐	☐
Anemia	☐	☐
Ulcer	☐	☐
High Cholesterol	☐	☐
Other _____		
Allergic/Immunologic		
Environmental Allergies	☐	☐
Lupus	☐	☐
Rheumatoid Arthritis	☐	☐
Drug Allergies	☐	☐
Sjogrens Syndrome	☐	☐
Other _____		

If you answered yes to any of the above, or have a condition not listed, please explain:

_____

_____

Doctor's Signature _____ Date _____/_____/_____

MEDFIELD EYE ASSOCIATES AND HOPKINTON EYE ASSOCIATES

www.myeyeassociates.com

Financial Policy

Medfield/Hopkinton Eye Associates acknowledges that it is a privilege to provide eye care to your family. We would like to give the best care at a reasonable fee. In order to hold billing costs to a minimum we expect payment at the time services are rendered, unless prior arrangements have been made. In order to be able to continue to see our patients in a timely manner for urgent issues we will charge a $40 fee for appointments which are not cancelled 24 hours in advance.

As per *your* contract with your insurance company, at the time of service you are to:

1. Present your insurance card and inform us of any vision plan.
2. Be prepared to pay your co-payment/co-insurance as stipulated in your contract (found on the face of your insurance card). In most cases, no co-pay will be collected for preventative services. However, if additional issues are addressed during the visit, a co-pay will be required.
3. Inform the office of any insurance, billing or contact (telephone/address) changes.
4. Be prepared to pay any deductible as stipulated in your contract with your insurance company. It is your responsibility to check the status of your deductible with the insurance company. We are unable to do this for you since we are not privy to this information so please review this information prior to your visit.

For your convenience we accept MasterCard, Visa, Discover, Amex, checks or cash. If your check is returned for non-sufficient funds, the bank will debit your account for the amount of the check, plus any applicable fees and we will bill you a $25 service charge. The use of a check for payment is your acknowledgement of this policy.

If someone other than a parent brings your child for care, they must provide the above information and pay the appropriate charges on your behalf.

_____ _____

Patient Signature/Parent or Guardian if under 18 Date