

PATIENT INFORMATION & MEDICAL HISTORY

Patient: _____ Date of Birth: _____ Sex: M / F
 Address: _____ Home Phone: _____ Cell: _____
 City: _____ State: _____ ZIP: _____ Soc. Sec. No.: _____
 Parent *or* Guardian: _____ Phone: _____ DOB: _____
 e-Mail: _____ Employer: _____ Work Phone: _____
 Optometrist: _____ Referring Doctor: _____
 Primary Care Physician: _____ Pharmacy: _____
 Spouse: _____ DOB: _____ Employer: _____
 Emergency Contact: _____ Phone: _____

Please answer the following questions about your medical status and history:

1. List the medications you take, if any: _____
2. List any eye medications that you currently use: _____
3. List any eye disease (e.g. glaucoma, cataract, "lazy" eye, etc.) you have had: _____
4. List any surgeries you have had in the last 5 years: _____
5. List any hospitalizations in the last 5 years: _____
6. List any food or drug allergies: _____

REVIEW OF SYSTEMS

Do you currently have any of the following?	Yes	No	If YES, please explain:
Diabetes, high blood pressure, arthritis, thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic fever, fatigue, weight gain/loss, epilepsy, anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/nose/throat (e.g. hearing loss, sinus or throat trouble)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Problems/Disease (e.g. chest pain, irregular heart beat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory (e.g. shortness of breath, asthma, emphysema, TB)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal (e.g. heartburn, abdominal pain, diarrhea, ulcers)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary (e.g. pain or discomfort, blood in urine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin (e.g. rashes, excessive dryness, psoriasis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal (e.g. muscle aches, joint pain, swollen joints)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic (e.g. numbness, weakness, headaches, paralysis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric (e.g. depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer/Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	_____

FAMILY HISTORY (please indicate any family members that have been treated for the following)

Diabetes _____ Stroke _____ Glaucoma _____
 High Blood Pressure _____ Heart Disease _____
 Macular Degeneration _____ Other _____

SOCIAL HISTORY (please indicate how much, if any, of the following substances you use)

Caffeine _____ Alcohol _____ Tobacco _____ Other _____

CONTINUE TO BACK OF FORM

Reviewed on:	By:	
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PRIMARY INSURANCE

Insurance Name: _____

Subscriber Name: _____

Date of Birth: _____

SECONDARY INSURANCE

Insurance Name: _____

Subscriber Name: _____

Date of Birth: _____

I authorize DMES to speak to the following people regarding my health information as deemed necessary:

Spouse: _____ Relative/Friend: _____ None Authorized:

FINANCIAL POLICY STATEMENT

(please read and sign below before your exam)

Our Patients With Insurance Coverage

As a courtesy, we bill your insurance carriers for you. We will set aside, for 45 days, that part of the balance which the insurance is expected to cover. If your insurance carrier does not send payment within 45 days, the balance is then due payable by you, unless other payment arrangements have been made with the Bookkeeping Supervisor. Most insurance companies only pay a portion of the fees incurred. We expect that your share for each procedure will be paid at the time of treatment.

We remind you that insurance coverage is an agreement between you and the insurance carrier; therefore, the account is in your name and final responsibility for any unpaid balance will be yours.

Additional Facts You Should Know

- **Medicare does not cover refractions;** therefore payment for refractions is expected from the patient at the time of treatment.
- Routine non-medical exams may not be covered by your insurance policy. If you are unsure, please contact your carrier *before* your visit.
- Insurance should not be expected to be a pay-all; it is only meant to be an aid.

I UNDERSTAND IF THE DOCTOR FINDS AN OCULAR MEDICAL CONDITION THROUGH THE COURSE OF MY EXAM, MY VISIT WILL BE BILLED TO MY MEDICAL INSURANCE. IT WILL NOT BE BILLED AS A WELL-EYE VISIT THROUGH MY VISION PLAN OR AS AN ANNUAL ROUTINE EYE EXAM THROUGH MY MEDICAL INSURANCE.

For Our Patients Without Insurance Coverage: Payment is expected at the time of treatment.

Payment Options

Our office may send monthly statements to each account with an outstanding balance regardless of insurance involvement. Payment may be made in the form of cash, personal check, money order, or credit card (MasterCard, Visa, American Express, and Discover).

I authorize any information in my medical record (including cell phone number) to be released to insurance companies and billing/debt collection contractors as may be needed to process claims for reimbursement.

I authorize payment of medical/vision benefits to Des Moines Eye Surgeons for services rendered.

I have read and agree to the conditions stated in the Financial Policy of Des Moines Eye Surgeons.

Signature: _____ **Date:** _____