SWEDBERG EYE CARE – NEW PATIENT INFORMATION

Please fill out the information to the best of your ability.
Complete and accurate information allows us to give you the best medical care possible.
This form will need to be updated every 3 years per insurance regulation.

Personal Demographic Information

First Name: ______________ MI: ____ Last Name: ______________
Date of Birth: ____________ Gender (must include for Tricare): _______
Preferred Language: __________ Interpreter Needed? □ Yes □ No
Mailing Address: ____
Home Phone #: _____________ Cell Phone #: ___________________

May we leave detailed messages regarding care? □ Yes □ No

Email Address: ____
Employer: __________________ Employer Phone: ______________________
Marital Status: _______________ Partner/Spouse's Name:________________

Primary Care Physician (PCP): ____
Primary Care Facility: ____
Referring Physician: ____

Emergency Contact Name: ____________________ Relationship: __________
Emergency Contact Phone: ____
May we disclose medical information in the event of an emergency? □ Yes □ No
Preferred Pharmacy and Location: ______________________________________

Insurance Information (Please fill out even if we have a copy)

Primary	Secondary
Primary Insurance: _______________	Secondary Insurance: ______________
Member ID #:____________________	Member ID #:____________________
Group #: ________________________	Group #: ________________________
Policy Holder: [] Same as patient	Policy Holder: [] Same as patient
[] Other ________________________	[] Other ________________________
Policy Holder Date of Birth: ________	Policy Holder Date of Birth: ________
Relationship to Patient: ___________	Relationship to Patient: ___________

History of Present Illness and Chief Complaint

Patient Name: ____________________ Date of Birth: ______________ Last Eye Exam? _____________

Please note: As a surgical clinic accepting only medical insurance, we address medical issues and generally do not perform routine screening exams. Please describe what we are addressing at your visit today.

What issue can we address today? ____

Onset (When did symptoms start?)

___ hours / days / weeks / months / years □ Unsure

Location (Where is the issue?)

□ Right Eye □ Left Eye □ Both Eyes □ Unsure □ Other: ___________

Duration (How long do symptoms last?)

□ Constant □ Fluctuates □ Intermittent □ Unsure

Severity (How bad are symptoms?)

□ Absent □ Mild □ Moderate □ Severe □ Debilitating

Quality (Description / What does it feel like?)

□ Aching □ Blurry □ Burning □ Bump □ Crusting □ Double Vision □ Discharge □ Distorted Vision □ Drooping

□ Dryness □ Flaky □ Flashes of Light □ Floaters □ Foreign Body Sensation □ Glare □ Haloes □ Headache

□ Itching □ Leathery Appearance □ Light Sensitive □ Missing Vision □ Obstructed Vision

□ Ocular Migraine □ Redness □ Spasm/Twitching □ Stabbing Pain □ Swelling □ Watering □ Wavy vision

□ Vision Loss (Central / Temporary / Permanent) Other: _____________________________

Vision (How well do you see even WITH glasses?)

□ No change □ Difficulty with distance vision □ Difficulty with near vision □ Everything is blurry

□ Vision Fluctuates throughout the day □ Vision worse in the morning but gets better

Timing (What triggers it?)

□ Allergies □ Blinking □ Driving in the rain □ Going Outside □ Headlights □ Lights □ Rubbing □ Sleeping

□ Waking up and opening eyes □ Wind/Cold □ Unsure

Modifying Factors (What makes it better or worse?)

□ Artificial tears □ Cold Compresses □ Warm Compresses □ Prescription Medication: __________________

□ Nothing

Has this happened before?

□ Yes □ No □ Unsure

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: ______________________ Date of Birth: ________________

Smoking: □ current smoker □ former smoker □ history of second-hand smoke □ never smoked

Alcohol Use: □ No □ Yes **Drug Use:** □ No □ Yes

Allergies: The technician will reconcile your allergies during intake. Please bring a list of allergies if needed.

Medications: The technician will review your medications with you during your workup. Please bring a separate list of your medications to your appointment for reconciliation.

Past Ocular History: (Please mark all that apply) **□ No history of eye issues**

□ Amblyopia (Lazy Eye)
□ Corneal Disorder (Fuch's, other)
□ Glaucoma
□ Macular Degeneration
□ Astigmatism
□ Diabetic Retinopathy
□ Hyperopia (Farsighted)
□ Myopia (Nearsighted)
□ Cataracts
□ Dry Eye
□ Iritis / Uveitis
□ Retinal Detachment
□ Other: ____

Ocular Surgeries: (Please mark all that apply) **□ No prior ocular surgery**

R L
□ □ After-Cataract Laser
□ □ Blepharoplasty (Lid Surgery)
□ □ Cataract Surgery
□ □ Corneal Transplant
□ □ Glaucoma Surgery (Trab/Tube)
□ □ Glaucoma Laser

R L
□ □ LASIK / PRK / RK
□ □ Laser Retinal Surgery
□ □ Membrane Peel
□ □ Retinal Detachment Repair
□ □ Strabismus (eye muscle surgery)
□ □ Other: _____________________________________

Other Medical History: **□ No history of illnesses**

□ Anemia
□ Anxiety
□ Arthritis
□ Arrhythmia
□ Asthma
□ Cancer
□ COPD
□ Depression
□ Diabetes
□ Type 1
□ Type 2
□ Fibromyalgia
□ Headache
□ Hearing Loss
□ Heart Attack
□ Hepatitis
□ Herpes
□ High Cholesterol
□ HIV/AIDS
□ Hypertension
□ Kidney Disease
□ Liver Disease
□ Lupus
□ Lyme Disease
□ Migraine
□ Multiple Sclerosis
□ Parkinsons Disease
□ Polymyalgia Rheumatica
□ Rheumatoid Arthritis
□ Stroke
□ Thyroid Disease
□ Other: __________________________________

General Surgeries/Procedures: (Please list) ____

Family History: (Please indicate relationship) **□ No history of illnesses** **□ History unknown**

□ Blindness □ Cancer □ Cataracts □ Glaucoma □ Macular Degeneration □ Retinal Detachment

SWEDBERG EYE CARE FINANCIAL POLICY

We are committed to providing you with the best possible eye care. As a courtesy, we will bill your medical insurance on your behalf.

Payment for services is due at time of service unless payment arrangements have been made in advance.

1. **You are responsible for understanding your insurance benefits**. Your insurance coverage is a contract between you, your employer and/or the insurance company but we can help clarify information for you.
2. **HMO Patients: You are responsible for obtaining any and all referrals from your Primary Care Physician (PCP) and Authorization from your insurance plan, before arriving at your appointment**. Failure to do so can result in denial of your claim and you being responsible for the full balance of your bill.
3. **Not all services are covered by medical insurance.** Medical and Vision insurance are NOT the same thing. A glasses prescription is usually not covered by medical insurance per insurance guidelines.
4. **As the patient, you are responsible for payment for services received and all balances are your responsibility.** We will do our best to bill your insurance first. We accept cash, Visa, Mastercard, and personal checks payable to Steven Swedberg, MD, PS. Convenient payment plans may be arranged.
5. **Please make a secure online payment on our website SWEDBERGEYE.COM. All phone payments are processed via our website.**
6. **No-showing to an appointment is subject to a $200.00 No-Show fee. Late cancellation (less than 24 hours) will result in a $100 fee. There will be a one-time allowance before this fee is enforced. Three (3) no-show or late cancellation occurrences may result in dismissal from the practice.**
7. **There will be a fee of $60 for all NSF checks.**
8. **Past due accounts over 60 days may be charged a maintenance fee of $5.00 per month.**
9. **Past due accounts over 90 days may face collection proceedings.**

We must emphasize that, as medical care providers, our relationship is with you, not your insurance company. Any disputes between you and them must be resolved by you, the patient. We will gladly discuss your proposed treatment and answer any questions related to your insurance.

We realize that temporary financial situations may affect timely payment of your account. If such issues do arise, we encourage you to contact us promptly for assistance in the management of your account. We are happy to make your visits more affordable for you and will work with you to establish a plan that can work for everyone.

Patient Signature (parent if minor): ___________________________________Date: _______________

Notice of Privacy Practices

This **Notice of Privacy Practices** describes how your health information may be used and disclosed and how you may access your information.

- We keep a record of the health care services we provide you.
- You may ask for your records at any time.
- You may ask to correct or amend your record at any time.
- We will not disclose your medical records to others unless you sign a Release of Medical Records Request Form or if the law authorizes us to do so.
- Supplying medical records to an outside agency may result in processing and administrative fees.
- Insurance companies require that we keep a copy of your insurance card on file for identification purposes. A copy of this is kept in a secure internal database.
- We require a copy of your identification on file to cross reference with your insurance information to reduce the risk of identity theft or improper use of insurance benefits. This copy is kept in a secure internal database.

By signing below, I acknowledge receipt of the **Notice of Privacy Practices.**

Signature ____ Date ____________________

AUTHORIZATION TO BILL - MEDICARE / MEDIGAP / MEDICARE ADVANTAGE / COMPLETE

I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Steven Swedberg, MD, for any service furnished to me by that physician. I authorize release to the Centers for Medicare and Medicaid Services and its agents any medical information about me needed to determine the payments for related services.

□ **Does not apply**

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Signature of Beneficiary (Patient), Guardian, or Personal Representative

____

Printed Name of Beneficiary (Patient), Guardian or Personal Representative

____

Date