

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.

Patient Personal Information

First Name: _____ MI: _____ Last Name: _____
Date of Birth: _____ Gender (must include for Tricare): _____
Preferred Language: _____ Interpreter Needed? Yes No
Mailing Address: _____
Primary 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: _____
Preferred Pharmacy and Location: _____
Emergency Contact Name: _____ Relationship: _____
Emergency Contact Phone: _____
May we disclose medical information to this contact in the event of an
emergency? Yes No

Insurance Information

Primary Insurance: _____	Primary Insurance: _____
Member ID #: _____	Member ID #: _____
Group #: _____	Group #: _____
Policy Holder: <input type="checkbox"/> Same as patient <input type="checkbox"/> Other _____	Policy Holder: <input type="checkbox"/> Same as patient <input type="checkbox"/> Other _____
Policy Holder Date of Birth: _____	Policy Holder Date of Birth: _____
Relationship to Patient: _____	Relationship to Patient: _____

Overall Health History

Social History	Yes/No	Details
Tobacco Use	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Tobacco <input type="checkbox"/> Chew <input type="checkbox"/> Vape
Alcohol Use	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Liquor <input type="checkbox"/> Beer <input type="checkbox"/> Wine
Drug Use	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Marijuana <input type="checkbox"/> Injectable <input type="checkbox"/> Cocaine <input type="checkbox"/> Other
Prescription Painkiller Use	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Opioid <input type="checkbox"/> NSAID <input type="checkbox"/> Aspirin <input type="checkbox"/> Tylenol <input type="checkbox"/> Other

Major Surgeries None

Procedure	Date
_____	_____
_____	_____
_____	_____

Medication Allergies No known medication allergies

Medication	Reaction	Last Used
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you have more allergies than there is room for please attach a separate list.

Review of Systems:

ALLERGY	CARDIO	ENDO	ENT	GASTRO	GENITO
<input type="checkbox"/> Seasonal	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> CROHNS	<input type="checkbox"/> Prostate cancer
<input type="checkbox"/> Pet	<input type="checkbox"/> heart disease	<input type="checkbox"/> Thyroid	<input type="checkbox"/> tinnitus	<input type="checkbox"/> IBS	<input type="checkbox"/> kidney disease
<input type="checkbox"/> Hay fever	<input type="checkbox"/> palpitations	<input type="checkbox"/> heat or cold intolerance	<input type="checkbox"/> sinus issues	<input type="checkbox"/> GERD	<input type="checkbox"/> menopause
<input type="checkbox"/> Food	<input type="checkbox"/> chest pain		<input type="checkbox"/> sleep apnea		
	<input type="checkbox"/> PACEMAKER				

HEMATO	MUSCULO	NEURO	PSYCH	RESPIRATORY	SKIN
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Headaches	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Asthma	<input type="checkbox"/> Skin cancer
<input type="checkbox"/> easy bleeding or bruising	<input type="checkbox"/> Gout	<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Depression	<input type="checkbox"/> COPD	<input type="checkbox"/> eczema
<input type="checkbox"/> Blood thinners	<input type="checkbox"/> chronic joint pain or swelling	<input type="checkbox"/> Migraines	<input type="checkbox"/> ADHD	<input type="checkbox"/> sarcoidosis	<input type="checkbox"/> acne
	<input type="checkbox"/> DVT	<input type="checkbox"/> Parkinsons	<input type="checkbox"/> PTSD	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> rosacea
		<input type="checkbox"/> MS			<input type="checkbox"/> rash, etc.

Please bring a separate list of your medications to your appointment.

The clinical staff will go over it with you at intake.

Eye History

Intraocular Surgical History

Procedure	Eye		
<input type="checkbox"/> Cataract Surgery	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Glaucoma Surgery	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Laser Surgery (LPI, SLT, YAG)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> LASIK	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Floater removal/Wrinkle peel	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Lid or Eye Muscle	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Injections	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Transplant	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Other			

Other Ocular-Related History

Long-term steroid use (Prednisone, Dexamethasone, Methotrexate, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye trauma (falls, direct impact to the eye, motor accident involving face, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood transfusions (major surgery, major blood loss, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Migraines	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Raynaud's or other vascular issues	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood thinner use (Coumadin, Warfarin, Xarelto, Aspirin, NSAIDs, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sleep Apnea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of iritis/uveitis/inner eye infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Contact Lens Use	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Work-related eye injury? (Chemical exposure, foreign body, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Family History of Ocular Issues:

- Blindness
- Glaucoma
- Macular Degeneration
- Retinitis Pigmentosa
- 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. **Appointments that are not cancelled or rescheduled at least 24 hours in advance will be subject to a \$100.00 No-Show fee.**
7. **There will be a fee of \$40 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. Release forms are available on our website at www.SwedbergEye.com
- Supplying medical records to an outside agency may result in processing and administrative fees.

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.

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

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

Date