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 service 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:		
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:	Member/ID Number:	Group #:
Policy Holder:	Policy Holder Date of Birth:	
Secondary Insurance:	Member/ID Number:	Group #
Policy Holder:	Policy Holder Date of Birth:	

See Reverse Side

SWEDBERG EYE CARE - NEW PATIENT QUESTIONAIRRE

Patient Name: _____ Date of Birth: _____ Today's Date: _____

What brings you to our office? ☐ Establish Care ☐ Transfer of Care ☐ Second Opinion

Diagnosis:_____ Date Diagnosed: _____ Diagnosed By:_____

Current Ocular Concern

Vision

□ Missing
□ Blurred
□ Trouble reading
□ Trouble with street signs
□ Double Vision
□ Flashes
□ Floaters
□ Haloes
□ Veil/Curtain

Feeling

□ Headache
□ Lid Drooping
□ Change in pupil size
□ Aching pain
□ Temple pain
□ Jaw pain
□ Nausea
□ Burning
□ Stinging
□ Itching
□ Watering
□ Holding lids up
□ Red
□ Light sensitive
□ Swelling
□ Other

Onset

□ Today □ Days □ Weeks
□Months □ Years □ Unsure

Eye

□ Right □ Left □ Both

What triggers it?

_____

What makes it worse?

_____

What makes it better?

_____

How often do you experience symptoms?

□ Constant
□ Intermittent
□ Occasionally
□ Rarely

How Severe?

□ Mild
□ Moderate
□ Severe
□ Absent

Treatment

□ Drops (specify below)
□ Warm compresses
□ Nothing so far
□ Other _____

Drop Top Color

(choose all that apply)

□ Blue □ Teal □ Purple
□ Orange □ Yellow □ Green
□ White □ Pink □ Ointment

Dosage

□ Morning / Bedtime
□ 2 / 3 / 4 x day
□ Other _____

Compliance

□ Consistent
□ Miss a day sometimes
□ Often forgets

Family History of Ocular Issues:

☐ Glaucoma ☐ Macular Degeneration ☐ Retinitis Pigmentosa ☐ Blindness ☐ Retinal Detachment

Eye-Specific History

Patient Name: _____

Intraocular Surgical History (Cataract surgery, laser for pressure, retinal detachment repair, etc)			
Procedure	**Eye**	**Surgeon**	**Date**
□ Cataract Surgery	☐ Right ☐ Left ☐ Both		
□ Glaucoma Surgery	☐ Right ☐ Left ☐ Both		
□ Laser Surgery	☐ Right ☐ Left ☐ Both		
□ LASIK	☐ Right ☐ Left ☐ Both		
□ Floater removal/Wrinkle peel	☐ Right ☐ Left ☐ Both		
□ Lid or Eye Muscle	☐ Right ☐ Left ☐ Both		
□ Injections	☐ Right ☐ Left ☐ Both		
□ Transplant	☐ Right ☐ Left ☐ Both		
□ Other	☐ Right ☐ Left ☐ Both		

Current Ocular Medication - Feel free to write down the cap color if you cannot remember the name				
Medication	**Which eye?**	**Dosage**	**Taking since**	**Side effects?**
	☐ Right ☐ Left ☐ Both			
	☐ Right ☐ Left ☐ Both			
	☐ Right ☐ Left ☐ Both			

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

Social History	Yes/No	Details
Tobacco Use	☐ Yes ☐ No	☐ Tobacco ☐ Chew ☐ Vape ☐ Every Day ☐ Socially
Alcohol Use	☐ Yes ☐ No	☐ Liquor ☐ Beer ☐ Wine ☐ Every Day ☐ Socially
Illicit Drug Use	☐ Yes ☐ No	☐ Marijuana ☐ Injectable ☐ Cocaine ☐ Other
Prescription Painkiller Use	☐ Yes ☐ No	☐ Opioid ☐ NSAID ☐ Aspirin ☐ Tylenol ☐ Other

See Reverse Side

Overall Health History

Patient Name: _____

Primary Care Physician: _____ Preferred Pharmacy: _____

Review of Systems - Circle Appropriate Option or write in additional info	Yes/No
Cancer (please specify type)	☐ Yes ☐ No
Cardiovascular (Hypertension, palpitations, chest pain, A-FIB, etc.)	☐ Yes ☐ No
Ear/nose/throat (e.g., hearing loss, sinus problems, allergies, etc.)	☐ Yes ☐ No
Endocrine (e.g., Diabetes, Thyroid)	☐ Yes ☐ No
Gastrointestinal (e.g., GERD, IBS, Crohn's, abdominal pain, diarrhea, etc.)	☐ Yes ☐ No
General Health: Chronic fever, unexpected weight loss/gain, fatigue, etc.	☐ Yes ☐ No
Genitourinary (e.g., pain or discomfort, blood in urine, prostate issues, etc.)	☐ Yes ☐ No
Integumentary (skin) (e.g., rashes, excessive dryness, hives, etc.)	☐ Yes ☐ No
Musculoskeletal (e.g., muscle aches, joint pain, arthritis, etc.)	☐ Yes ☐ No
Neurologic (e.g., numbness, weakness, headaches, memory loss, etc.)	☐ Yes ☐ No
Psychiatric (e.g., depression, anxiety, PTSD, ADHD, etc.)	☐ Yes ☐ No
Respiratory (e.g., shortness of breath, wheezing, COPD, asthma, etc.)	☐ Yes ☐ No
Sexually transmitted diseases (HIV+, potential exposure, etc.)	☐ Yes ☐ No

Major Surgeries

Procedure	Date

Systemic Medication ☐ No medications ☐ Over-the-counter supplements

Systemic Medication	Dosage/Timing	Used for:

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

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.

FINANCIAL POLICY

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

Payment for services are 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.
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, <u>not your insurance company</u>. <u>Any disputes between you and them must be resolved by you, the patient.</u> 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.

GLASSES PRESCRIPTION (REFRACTION) ACKNOWLEGEMENT

By signing below you acknowledge that we have informed you of the following:

- Your glasses prescription (refraction) is not covered by Medical insurance.
- We DO NOT bill Vision insurance (VSP, Davis, EyeMed, etc.) plans
- The fee for a new glasses prescription is $70.00 in addition to whatever copay your insurance company requires for today's visit.

Please contact your insurance company if you have further questions.

I have read the above information and understand that my glasses prescription is a **non-covered service** by my Medical insurance. I accept full finanial responsibility for the cost of this service. I understand that my co-payment for today's office visit is a separate fee per my medical insurance carrier from the refraction fee.

Patient Signature (parent if minor): _____ Date: _____

See Reverse Side

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 of 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.**

Patient or Legal Guardian: _____
Date: _____
Printed Name: _____
Relationship: _____

AUTHORIZATION TO BILL

MEDICARE / MEDIGAP / MEDICARE ADVANTAGE / COMPLETE

Patient's Name: _____ Date of Birth: _____

Medicare Member ID # _____ Account # _____

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, Guardian, or Personal Representative

_____

Printed Name of Beneficiary, Guardian or Personal Representative

_____

Date

SWEDBERG EYE CARE

OPHTHALMOLOGY CLINIC

Steven H. Swedberg, MD
Eye Physician & Surgeon

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **Date of Birth:**_____

Phone: H) _____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:**_____

Facility Address:_____ **Facility Fax:**_____

City, ST, Zip: _____

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: _____
☐ Specific Information Requested:
_____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: Steven H Swedberg, MD PS

Address: 21827 76th Avenue West, Suite 102

City, State, Zip: Edmonds, WA 98026

☐ **Please mail records.**
☐ **Please fax records.**

Fax: (425) 778-5600 **Phone:** (425) 778-2500

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____. **If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

_____ _____

Printed name of Authorized Representative

Relationship / Capacity to patient

_____

Address and telephone number of authorized representative