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.

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 to this contact in the event of an emergency? □ Yes □ No

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

Primary Insurance: _____
Member ID #:_____
Group #: _____
Policy Holder: [] Same as patient
[] Other _____
Policy Holder Date of Birth: _____
Relationship to Patient: _____

Secondary Insurance: _____
Member ID #:_____
Group #: _____
Policy Holder: [] Same as patient
[] Other _____
Policy Holder Date of Birth: _____
Relationship to Patient: _____

New Patient Intake – History of Present Illness or Condition

Patient Name: _____ Date of Birth: _____ Last Eye Exam? _____

Onset (When did symptoms start?)

___ hours / days / weeks / months / years [] Unsure

Characteristics (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 Patches of Vision [] Obstructed Vision

[] Redness [] Spasm/Twitching [] Stabbing Pain [] Swelling [] Watering [] Wavy vision

[] Vision Loss (Central / Temporary / Permanent) Other: _____

Location (Where is the issue?)

[] Right Eye [] Left Eye [] Both Eyes [] Unsure [] 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

Duration (How long do symptoms last?)

[] Constant [] Fluctuates [] Intermittent [] Unsure

Severity (How bad are symptoms?)

[] Absent [] Mild [] Moderate [] Severe [] Debilitating

Timing (What triggers it?)

[] Waking up and opening eyes [] Going Outside [] Headlights at night [] Lights [] Rubbing Eye [] Wind/Cold

[] Unsure

Aggravating Factors (What makes it worse?)

_____ [] Unsure

Relieving Factors (What makes it better?)

[] Artificial tears [] Cold Compresses [] Warm Compresses [] Prescription Medication: _____

[] Nothing

Has this happened before?

[] Yes [] No [] Unsure

Have you been diagnosed with the following? [] Cataract [] Dry Eye [] Glaucoma [] Macular Degeneration

Overall Health History

Social History	Yes/No	Details
Tobacco Use	☐ Yes ☐ No	☐ Tobacco ☐ Chew ☐ Vape
Alcohol Use	☐ Yes ☐ No	☐ Liquor ☐ Beer ☐ Wine
Drug Use	☐ Yes ☐ No	☐ Marijuana ☐ Injectable ☐ Cocaine ☐ 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
☐ Seasonal ☐ Pet ☐ Hay fever ☐ Food	☐ High blood pressure ☐ heart disease ☐ palpitations ☐ chest pain ☐ PACEMAKER	☐ Diabetes ☐ Thyroid ☐ heat or cold intolerance	☐ Hearing loss ☐ tinnitus ☐ sinus issues ☐ sleep apnea	☐ CROHNS ☐ IBS ☐ GERD	☐ Prostate cancer ☐ kidney disease ☐ menopause

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

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

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

Preferred Pharmacy and Location: _____

Eye History

Intraocular Surgical History	
Procedure	**Eye**
□ Cataract Surgery	☐ Right ☐ Left ☐ Both
□ Glaucoma Surgery	☐ Right ☐ Left ☐ Both
□ Laser Surgery (LPI, SLT, YAG)	☐ 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	

Other Ocular-Related 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 issues	☐ 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

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.
- 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.

_____

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

_____

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

_____

Date