SWEDBERG EYE CARE
OPHTHALMOLOGY CLINIC
21827 76th Avenue West, Suite 102, Edmonds, WA 98026 **(425) 778-2500** fax (425) 778-5600

PATIENT INFORMATION FORM

Please fill out the information to the best of your ability. Complete and accurate information allows us to give you the best service possible.

PERSONAL INFORMATION

Name: First: _____ MI: _____ Last: _____

Date of Birth: _____ Social Security # _____ (Must include for Tricare) Gender: _____

Ethnicity / Language: _____

Do you need an interpreter (circle)? YES NO

CONTACT INFORMATION

Mailing address: _____

City: _____ State:____ Zip: _____

Primary Phone #:_____ Cell Phone #: _____

May we leave a message that contains medical information on your cell phone (circle)? YES NO

Email address: _____

Employer: _____ Phone: _____

Marital Status: _____Spouse's Name: _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Facility: _____

Referring Physician: _____ City: _____

Pharmacy _____ City: _____ Phone:_____

Person Responsible for Payment: _____

DOB: _____ Social Security #: _____ Relationship: _____

Phone: _____ Address: _____

City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID / Member Number: _____

Group #: _____ Policy Holder: _____ DOB: _____

Secondary Insurance: : _____ ID / Member Number: _____

Group #: _____ Policy Holder: _____ DOB: _____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to Dr. Steven H. Swedberg, MD PS as well as release of any information by provider or insurance company required for this account.
PAYMENT: I agree that I am responsible for providing up to date health insurance information and am financially responsible for the balance remaining after insurance adjudication. I agree to make payment arrangements for any unpaid balances due after 30 days after the billing statement.

SIGNED: _____ DATE: _____

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HEALTH HISTORY

Patient Name: _____ Date: _____

Medical History (check all that apply)

___ High Blood Pressure	___Hepatitis	___Glaucoma	___Retinal Detachment
___Heart Problems	___Thyroid Disease	___Keratoconus	___Strabismus
___Diabetes	___HIV Positive	___Cataract	___Eye Injury
___Arthritis	___Cancer	___Macular Degeneration	___Eye Surgery

Medications: _____	Medication Allergies:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list all Eye Surgeries and any Recent /Past Major Surgeries:

_____

_____

Review of Systems:	YES	NO	If YES, please explain
Do you have any of the following problems:	___	___	_____
Chronic fever, unexpected weight loss/gain, fatigue	___	___	_____
Ear/nose/throat problems (e.g. hearing loss, sinus problems)	___	___	_____
Heart Problems (e.g. chest pain, irregular heart beat)	___	___	_____
High Blood Pressure	___	___	_____
Respiratory problems (e.g. shortness of breath, wheezing)	___	___	_____
Hay Fever	___	___	_____
Gastrointestinal problems (e.g. abdominal pain, diarrhea)	___	___	_____
Urinary problems (e.g. pain or discomfort, blood in urine)	___	___	_____
Skin problems (e.g. rashes, excessive dryness)	___	___	_____
Musculoskeletal problems (e.g. muscle aches, joint pain)	___	___	_____
Neurologic problems (e.g. numbness, weakness, headaches)	___	___	_____
Endocrine problems (e.g. diabetes, thyroid)	___	___	_____
Psychiatric problems (e.g. depression, anxiety)	___	___	_____

Family History:

___ Blindness	___Crossed/Lazy Eye	___Glaucoma
___Retinal Detachment	___ Cataract	___Macular Degeneration

Social History:

Tobacco Use:	___Former	___Currently	___Never
Alcohol History:	___Occasionally	___Daily	___Never

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NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGMENT

We keep a record of the health care services we provide you. You may ask for your records at any time. You may also ask to correct that record. 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 outside agencies may result in a processing fee.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed and how you may access your information.

By signing below I acknowledge receipt of the **Notice of Privacy Practices**, and have been informed of our office **Financial Policy** and **Refraction Fee** on the previous page.

_____ _____
Patient or Legal Guardian Date

_____ _____
Printed Name Relationship

_____ _____
Printed name of person we may disclose medical information to in the case of an emergency. Relationship

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FINANCIAL POLICY

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

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

1. **You are responsible for understanding your insurance.** Your insurance 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 referrals from your Primary Care Physician and Authorization from your Insurance Plan, before coming to 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 a covered by medical insurance**. Medical and Vision insurance are NOT the same thing. A glasses prescription is not usually 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, Master Card, and checks payable to Dr. Steven H 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 on our website.**

6. **Missed appointments are subject to a $100 service charge.**

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.

We will gladly discuss your proposed treatment and answer any questions related to your insurance.

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

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help.

There will be a fee of $30 for all NSF checks. Past due accounts over 60 days may be charged a minimum of $5.00 per month. Past due accounts over 90 days may face collection proceedings.

Name: _____ Date: _____

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AUTHORIZATION TO BILL MEDICARE / MEDIGAP

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 Dr. Steven H. 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 Date

_____ _____
Printed Name of Guardian or Personal Representative Date

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GLASSES PRESCRIPTION (REFRACTION) ACKNOWLEDGMENT

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, DavisVision etc...).
- The cost is $70.00 plus your copay if you have one.
- Contact your insurance company if you have any further questions.

I have read the above information and understand that my glasses prescription is a **non-covered service** by my insurance. I accept full financial responsibility for the cost of this. I understand that the insurance copayment is separate from the refraction fee.

_____ _____

Patient signature (Parent for minor) Date