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

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

Eye-Specific History

Name: _____

Intraocular Surgical History			
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	_____	_____

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

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

Family History of Ocular Issues:

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

Overall Health History Name: _____

Primary Care Physician: _____ Preferred Pharmacy: _____

Review of Systems - Circle Appropriate Option or write in additional info

Integumentary: ☐ Skin cancer ☐ eczema ☐ acne ☐ rosacea ☐ rash, etc.

Ear/Nose/Throat: ☐ Hearing loss ☐ tinnitus ☐ sinus allergies ☐ sleep apnea

Respiratory: ☐ Asthma ☐ COPD ☐ sarcoidosis ☐ shortness of breath ☐ Other: _____

Cardiovascular: ☐ High blood pressure ☐ heart disease ☐ palpitations ☐ chest pain

Gastrointestinal: ☐ IBS ☐ GERD ☐ nausea ☐ vomiting ☐ abdominal pain, etc. ☐ Other: _____

Genitourinary: ☐ Prostate cancer ☐ kidney disease ☐ menopause ☐ Other: _____

Muscoloskeletal: ☐ Arthritis ☐ Gout ☐ chronic joint pain or swelling ☐ DVT ☐Other: _____

Neurological: ☐ Headaches ☐ Alzheimers ☐ Migraines ☐ Parkinsons ☐ MS ☐ Other: _____

Endocrine: ☐ Diabetes ☐ Thyroid Disease ☐ heat or cold intolerance ☐ Other: _____

Hemato/Lymphatic: ☐ High cholesterol ☐ easy bleeding or bruising ☐ Other: _____

Psychiatric: ☐ Anxiety ☐ Depression ☐ ADHD ☐ PTSD ☐ Other:_____

Allergies/Immunological: ☐ Environmental ☐ seasonal ☐ pet ☐ hay fever ☐ 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.

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

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

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.

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.

I have read the above information and understand that my glasses prescription is a **non-covered service** by my Medical insurance. **I accept full financial 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: _____

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.**

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, Guardian, or Personal Representative

_____

Printed Name of Beneficiary, Guardian or Personal Representative

_____

Date