MORLEDGE
FAMILY EYE CLINIC

1747 Poly Drive | Billings, Montana 59102 | T: 406/294-1994 & 406/294-1995 | F: 406/294-1996

Welcome to the Morledge Family Eye Clinic and Surgery Center!

This packet of information was created to help ***streamline*** your appointment. Before you arrive please print the forms and fill them out.

When it is time for your appointment please remember to bring the following:

1. A **list of your current medications** detailing the exact dose and how often you are taking the prescription
2. Your **insurance cards** and **identification**
3. The **forms** that you printed and filled out

As an ophthalmology practice, we are responsible for the complete health of your eyes. Your examination will likely include dilation of the pupils, a refraction (necessary to determine glasses prescription) and any additional testing the doctor deems necessary.

To ensure you are getting the best care possible, please plan on being in our office 1-2 hours.

We are looking forward to your visit!
If you are not able to make your appointment, please call our office to reschedule.

Thank you,

Morledge Family Eye Clinic

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AND SURGERY CENTER

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REGISTRATION INFORMATION (PLEASE PRINT)

TODAY'S DATE: _____

REASON FOR APPOINTMENT: _____

REFERRED HERE BY: _____PRIMARY CARE PROVIDER_____

PATIENT'S NAME: _____ [ ]DR [ ]MR [ ]MRS [ ]MS [ ]MISS
(last) (first) (M.I.)

BIRTHDATE: ___/___/_____ AGE: _____ SEX: [ ]F [ ]M MARITAL STATUS: [ ]S [ ]M [ ]OTHER
MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: **HOME** (_____) _____ **WORK** (_____) _____ **CELL** (_____) _____

SOCIAL SECURITY #: _____-____-_____ SPOUSE/GUARDIAN NAME: _____
Email address_____
SPOUSE OR GUARDIAN MAILING ADDRESS (IF DIFFERENT). IF SAME AS ABOVE, CHECK HERE [ ].

ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: **HOME** (_____) _____ **WORK** (_____) _____ **CELL** (_____) _____

YOUR OCCUPATION: _____ EMPLOYER: _____
EMPLOYER'S ADDRESS AND TELEPHONE: _____

WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY?

NAME: _____ RELATIONSHIP: _____
PHONE: **HOME** (_____) _____ **WORK** (_____) _____ **CELL** (_____) _____
ADDRESS: _____
HOSPITAL PREFERENCE:_____

PAYMENT INFORMATION

I WILL MAKE PAYMENT FOR SERVICES BY ONE OF THE FOLLOWING:
[ ] CASH OR CHECK [ ] PRIVATE INSURANCE [ ] MEDICARE [ ] MEDICAID [ ] WORKERS' COMP

I AGREE TO PAY MY PORTION OF ALL FEES PROMPTLY FOR SERVICES/DEDUCTIBLES/CO-PAYMENTS NOT COVERED BY MY CARRIER.
SIGNATURE OF PATIENT OR PARTY RESPONSIBLE FOR PAYMENT: _____

MEDICARE ASSIGNMENT AUTHORIZATION: I AUTHORIZE MEDICARE TO ASSIGN PAYMENT MADE ON MY BEHALF TO MORLEDGE FAMILY EYE CLINIC FOR SERVICES PROVIDED TO ME. I AUTHORIZE THE RELEASE TO MEDICARE OF ANY INFORMATION NEEDED TO DETERMINE BENEFITS PAYABLE.
NOTE: I UNDERSTAND THAT MEDICARE DOES NOT PAY FOR THE REFRACTION PART OF AN EYE EXAM (THE EYE GLASSES PRESCRIPTION). I AGREE THAT I AM RESPONSIBLE FOR THIS CHARGE.
SIGNATURE OF PATIENT OR PARTY RESPONSIBLE FOR PAYMENT: _____

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Refraction/Glasses Check:

In order for the doctor to prescribe you corrective lenses/glasses, a procedure called refraction will need to be done. Many medical insurances, including Medicare, usually do not cover this procedure. **Our office charges $35 for this procedure.** Please read below and mark an "X" accordingly.

__Option 1: I **WANT** the refraction. I understand that the office may ask for payment at the time of service, and I am responsible for payment.

__Option 2: I **DO NOT WANT** the refraction. I understand with this choice I am not responsible for payment.

Please let us know if you have any questions!

_____ _____
Print Name Date

_____
Signature

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Birth Date: _____

Gender: ☐ Male ☐ Female

Chief Complaint – Eyes – Are you currently experiencing any of the following:

Blurred Vision	☐ Yes	☐ No	Glare/Light Sensitivity	☐ Yes	☐ No
Burning	☐ Yes	☐ No	Itching	☐ Yes	☐ No
Distorted Vision/Halos	☐ Yes	☐ No	Loss of Side Vision	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No	Loss of Vision	☐ Yes	☐ No
Dryness/Dry Eyes	☐ Yes	☐ No	Mucous Discharge	☐ Yes	☐ No
Excess Tearing/Watering	☐ Yes	☐ No	Redness	☐ Yes	☐ No
Eye Pain or Soreness	☐ Yes	☐ No	Sandy or Gritty Feeling	☐ Yes	☐ No
Flashes/Floaters in Vision	☐ Yes	☐ No	Tired Eyes	☐ Yes	☐ No
Foreign Body Sensation	☐ Yes	☐ No			

Has there been a change in your vision since your last exam? ☐ Yes ☐ No

If yes, explain: _____

Ocular Conditions – Do you currently have or have you been diagnosed with the following:

Cataracts	☐ Yes	☐ No	Infection of Eye or Lid	☐ Yes	☐ No
Crossed Eyes	☐ Yes	☐ No	Lazy Eye	☐ Yes	☐ No
Drooping Eyelid	☐ Yes	☐ No	Retinal Disease	☐ Yes	☐ No
Eye Injury	☐ Yes	☐ No	Styes or Chalazion	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Other_____	☐ Yes	☐ No

Medical History

Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ☐ Yes ☐ No If yes, how old is your present pair of lenses? _____

Have you ever had a reaction to LATEX? ☐ Yes ☐ No

If yes, please identify your reaction: _____

Do you have any allergies? ☐ Yes ☐ No

If yes, please specify: _____

Do you have any allergies to medications? ☐ Yes ☐ No

If yes, please list medications: _____

List any medications that you take (including oral contraceptives, aspirin, over the counter medications, and herbal supplements):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Cont.-

Family History

Disease / Condition				Relationship to You
Blindness	☐ Yes	☐ No	☐ ?	_____
Cataract	☐ Yes	☐ No	☐ ?	_____
Crossed Eyes	☐ Yes	☐ No	☐ ?	_____
Glaucoma	☐ Yes	☐ No	☐ ?	_____
Macular Degeneration	☐ Yes	☐ No	☐ ?	_____
Retinal Detachment/Disease	☐ Yes	☐ No	☐ ?	_____
Arthritis	☐ Yes	☐ No	☐ ?	_____
Cancer	☐ Yes	☐ No	☐ ?	_____
Diabetes	☐ Yes	☐ No	☐ ?	_____
Heart Disease	☐ Yes	☐ No	☐ ?	_____
High Blood Pressure (Hypertension)	☐ Yes	☐ No	☐ ?	_____
Kidney Disease	☐ Yes	☐ No	☐ ?	_____
Lupus	☐ Yes	☐ No	☐ ?	_____
Stroke	☐ Yes	☐ No	☐ ?	_____
Thyroid Disease	☐ Yes	☐ No	☐ ?	_____
Other	☐ Yes	☐ No	☐ ?	_____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you drive? ☐ Yes ☐ No

If yes, do you have visual difficulty when driving? ☐ Yes ☐ No If yes, please describe:____

_____

Do you use tobacco? ☐ Yes ☐ No

If yes, Type/Amount/How long: _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how often: _____

Do you use illegal drugs? ☐ Yes ☐ No

If yes, Type/Amount/How long: _____

Have you ever been exposed to or infected with HIV? ☐ Yes ☐ No

Health History – Do you currently have any problems in the following areas:

CARDIOVASCULAR

Implanted Defibrillator	☐ Yes	☐ No
Heart Trouble	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Angina	☐ Yes	☐ No
Previous Heart Bypass	☐ Yes	☐ No
Heart Valve Replace	☐ Yes	☐ No
Pacemaker or Stent	☐ Yes	☐ No
Blood Clot (DVT)	☐ Yes	☐ No

IMMUNOLOGIC

Syphilis	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No

CONSTITUTIONAL

Fever	☐ Yes	☐ No
Weight Loss	☐ Yes	☐ No
Weight Gain	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Mastectomy (R / L)	☐ Yes	☐ No

MOBILITY

Use Walker	☐ Yes	☐ No
Use Wheelchair	☐ Yes	☐ No
Use Cane or leg brace	☐ Yes	☐ No

INTEGUMENTARY (Skin)

MRSA	☐ Yes	☐ No
Eczema	☐ Yes	☐ No
Rosacea	☐ Yes	☐ No

Cont.-

HEMATOLOGIC / LYMPHATIC
- Anemia ☐ Yes ☐ No
- Bleeding Problems ☐ Yes ☐ No

MUSCULOSKETAL
- Arthritis / Rheumatoid ☐ Yes ☐ No
- Joint Pain ☐ Yes ☐ No
- Muscle Pain ☐ Yes ☐ No
- Hip or Knee Replace ☐ Yes ☐ No
- Back/Neck Surgery ☐ Yes ☐ No
- Paralysis ☐ Yes ☐ No

EARS, NOSE, THROAT
- Difficulty Hearing ☐ Yes ☐ No
- Use Hearing Aids ☐ Yes ☐ No
- Difficulty Swallowing ☐ Yes ☐ No

CRANIAL / FACIAL
- Chronic Cough ☐ Yes ☐ No
- Ear Infection ☐ Yes ☐ No
- Dry Mouth ☐ Yes ☐ No

ENDOCRINE
- Diabetes ☐ Yes ☐ No
- Thyroid/Other Glands ☐ Yes ☐ No
- Sign.Weight Loss/Gain ☐ Yes ☐ No

GASTROINTESTINAL
- Constipation ☐ Yes ☐ No
- Diarrhea ☐ Yes ☐ No
- Hepatitis ☐ Yes ☐ No

PSYCHIATRIC
- Anxiety ☐ Yes ☐ No
- Dementia ☐ Yes ☐ No
- Alzheimer's ☐ Yes ☐ No
- Short Term Memory ☐ Yes ☐ No
- Depression ☐ Yes ☐ No
- Bipolar ☐ Yes ☐ No

NEUROLOGICAL
- Headaches ☐ Yes ☐ No
- Migraines ☐ Yes ☐ No
- Seizures ☐ Yes ☐ No
- Stroke ☐ Yes ☐ No
- TIA ☐ Yes ☐ No
- Tremors ☐ Yes ☐ No
- Parkinson's ☐ Yes ☐ No
- MS ☐ Yes ☐ No

RESPIRATORY
- Asthma ☐ Yes ☐ No
- Bronchitis ☐ Yes ☐ No
- Emphysema ☐ Yes ☐ No
- COPD ☐ Yes ☐ No
- Sleep Apnea ☐ Yes ☐ No

GENITOURINARY
- Bladder ☐ Yes ☐ No
- Kidney ☐ Yes ☐ No
- Dialysis Fistula ☐ Yes ☐ No

Patient/Guardian Signature: _____ Date: _____

I have reviewed my previous Medical History Questionnaire and there are no changes.

_____ _____	_____ _____	_____ _____	_____ _____	_____ _____	_____ _____
Initial Date	Initial Date	Initial Date	Initial Date	Initial Date	Initial Date

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PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of the Morledge Family Eye Clinic and Surgery Center, LLC not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so we may best serve you. If you do not want any of your medical information provided to a family member, please check (√) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: ____ _______ yes _______ no

Parent: ____ _______ yes _______ no

Other:____ _______ yes _______ no

____ _______ yes _______ no

____ _______ yes _______ no

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only:____

____

____

PRINTED NAME____

Patient/Parent/Guardian Signature:____

Date: ___________________________________

- -

FOR OFFICE USE

Changes to above authorized by patient via phone:

Change	Date	Staff Initials

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ACKNOWLEDGMENT OF RECEIPT OF THE ***HIPAA NOTICE OF PRIVACY PRACTICES***

I acknowledge that I received (or was given the option to receive) a copy of the Morledge Family Eye Clinic's ***HIPAA Notice of Privacy Practices*** as required by the Health Insurance Portability and Accountability Act effective 03/15/2003.

_____
Patient's Name (please print)

_____ _____
Patient's Signature Date
(Patient Representative /Guardian's Signature)

Office Use Only

Patient given Privacy Notice, however:

- ☐ Patient **refused or did not** sign Acknowledgement form
- ☐ Patient **unable** to sign Acknowledgement form
- ☐ Patient states they have signed Acknowledgement from previously
- ☐ Copy of HIPAA acknowledgement declined by patient
- ☐ Patient declined copy of HIPAA Privacy Notice