

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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FAMILY EYE CLINIC
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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glare/Light Sensitivity	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Burning	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Itching	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Distorted Vision/Halos	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Loss of Side Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Double Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Loss of Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dryness/Dry Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mucous Discharge	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Excess Tearing/Watering	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Redness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye Pain or Soreness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sandy or Gritty Feeling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Flashes/Floaters in Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tired Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Foreign Body Sensation	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Infection of Eye or Lid	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Crossed Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lazy Eye	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drooping Eyelid	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Retinal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Styes or Chalazion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other_____	<input type="checkbox"/> Yes	<input type="checkbox"/> 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

Relationship to You

Disease / Condition

Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Cataract	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Crossed Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Macular Degeneration	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Retinal Detachment/Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
High Blood Pressure (Hypertension)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Thyroid Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> ?	_____

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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Previous Heart Bypass	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Valve Replace	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pacemaker or Stent	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Clot (DVT)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

IMMUNOLOGIC

Syphilis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No

CONSTITUTIONAL

Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weight Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weight Gain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mastectomy (R / L)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

MOBILITY

Use Walker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Use Wheelchair	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Use Cane or leg brace	<input type="checkbox"/> Yes	<input type="checkbox"/> No

INTEGUMENTARY (Skin)

MRSA	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rosacea	<input type="checkbox"/> Yes	<input type="checkbox"/> 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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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
(Patient Representative /Guardian's Signature)

Date

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