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 DOCTOR_____

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** (_____) _____ **DAYTIME** (_____) _____ **CELL** (_____) _____
May we leave a message regarding appointments or your eye health on the above #s? [ ] yes [ ] no
EMAIL ADDRESS_____
SOCIAL SECURITY #: _____-____-_____ SPOUSE/GUARDIAN NAME: _____

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** (_____) _____
May we leave confidential information with your emergency contact? [ ] yes [ ] no
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: _____

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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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