Eye Care Avenue - Amy D. Rasmussen, OD

Today's Date: _____
Title (circle) Mr. Mrs. Dr. Ms. Miss
First Name: _____
Last Name: _____
Middle Name: _____
Preferred Name: _____

Please star * preferred contact number
Home Phone # _____
Work Phone # _____
Cellular Phone # _____
Email: _____

Please circle how you would like us to send you reminders: mail email text call
Address: _____
Date of Birth: ___/___/_____
Social Security # _____ Sex (circle): male/ female
Patient Employer/School: _____ Patient Occupation/Grade: _____
Responsible party if a minor_____ Relationship_____
Insured's Social Security: _____ Insured's Date of Birth: _____
Marital Status(circle) single married divorced widowed
Race: _____ Ethnicity(circle) Hispanic/Latino – Not Hispanic/Latino

Medical Information Update
Date of last eye exam: _____ Previous Eye Doctor _____
Do you wear glasses? Yes / No
Do you wear contact lenses? Yes / No Brand_____ Rx R_____ L_____
What is the main reason you came in for an examination? _____
How did you select our office?_____
Please check all symptoms you have currently **with your glasses or contact lenses on**:

____ blurred vision at distance	____ light flashes	____ pain	____ watering
____ blurred vision at near	____ floaters	____ redness	____ light sensitivity
____ eye fatigue	____ double vision	____ itching	____ headaches
____ halos around lights	other:_____		

Please circle any of the following eye health or health conditions you or your relatives may have:
Glaucoma: Self/Mom/Dad/Brother/Sister/Son/Daughter
Cataracts: Self/Mom/Dad/Brother/Sister/Son/Daughter
Blindness: Self/Mom/Dad/Brother/Sister/Son/Daughter
Crossed eye/Lazy eye: Self/Mom/Dad/Brother/Sister/Son/Daughter
Eye surgery (what type): _____Self/Mom/Dad/Brother/Sister/Son/Daughter
Eye injury(what type):_____Self/Mom/Dad/Brother/Sister/Son/Daughter
Asthma: Self/Mom/Dad/Brother/Sister/Son/Daughter
Cancer: Self/Mom/Dad/Brother/Sister/Son/Daughter
Diabetes: Self/Mom/Dad/Brother/Sister/Son/Daughter
High blood pressure: Self/Mom/Dad/Brother/Sister/Son/Daughter
Heart disease: Self/Mom/Dad/Brother/Sister/Son/Daughter
Thyroid: Self/Mom/Dad/Brother/Sister/Son/Daughter
Current Physician: _____Phone:_____
What medications are you currently taking? _____
What allergies to medications do you have? _____
Are you allergic to any anesthetics like Novocain? Yes/No
Are you currently pregnant or nursing? Yes/No
Do you drink alcohol? Yes/No Amount _____ Do you smoke? Yes/No Amount_____
Height _____ Weight _____

_____ _____
PATIENT SIGNATURE (or responsible party if a minor)* DATE

*Please make note that if the insurance company does not remit payment for services and materials within 90 days the patient and/or the insured has the responsibility to pay the account balance.

Please turn over →

Patient Name (Please print): _____

Signature on File

Please read the following information about our insurance policy and sign below.

1) I authorize use of the information on this form for all of my insurance submissions.
2) I authorize the release of information to all my **Insurance Companies.**
3) I understand that **I am responsible** for my bill.
4) I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
5) I authorize payment directly to my doctor.
6) I permit a copy of this authorization to be used in place of the original.
7) I authorize the signature on file to be used if I choose to pay for materials or services by credit card over the phone.

Signature of patient or guardian: _____ Date: _____

Office Policies

Please read all of the following office policies and sign below.

1) All insurance deductibles, co-pays and procedure fees must be paid for at the time of the visit.
2) Before any "extras" not covered by your insurance or materials (including frames, lenses and/or contact lenses) are ordered you must pay a deposit of at least half of the total amount due.
3) A dilated fundus examination allows the doctor to further evaluate the health of your eyes. Dilated fundus examinations are recommended every 1 – 2 years or even more frequently depending on your eye health.
4) Follow-up care is at no charge for glasses prescription within one month of your examination date and within two months of your contact lens fitting date. If you have any questions about your contact lenses or your glasses, please feel free to call the office and speak to a staff member.
5) Custom items such as eyeglass lenses, RGP contact lenses and certain eyeglass frames have a limited exchange or return policy. These items must be returned or exchanged within 30 days of the order date for credit minus a $50 restocking fee. Some insurance companies will not allow any changes after the initial order. Any custom items kept 30 days or more past the order date may not be exchanged or refunded.
6) Due to limited office space, we are unable to hold contacts and/or glasses past 2 months.
7) *Contact lens patients:* All contact lens wearers are advised to return for office visits to insure proper fitting and maintenance. **Please have your lenses on at least 3 hours prior to your appointment time.**
8) All returned checks will be subject to a $35 service charge.
9) If your account must be sent to a collection agency for non-payment you agree to be responsible for any costs of collection Eye Care Avenue may incur as a result of this account being placed with an outside collection agency. This amount may include a fee of up to 35% of the amount assigned for collection. You also agree to be responsible for any attorney fees or court costs that may be awarded by a court of jurisdiction.
10) I have been offered a copy of the HIPAA privacy policies for Eye Care Avenue.

Signature of patient or guardian: _____Date: _____