MUDGIL EYE ASSOCIATES
Health History Form

Patient's Name:	DOB:

As medical doctors and eye surgeons, we need to know about more than just the eyes. Please help us take care of you (*or your child*) by answering all questions to the best of your ability. Note that some areas may not apply.

Height: Weight:
Occupation (*grade, if student*)
If retired, occupation before retiring:
If college or graduate student, area of study:
Name of employer *or school*:
Pediatric patients ONLY:
*Mother's Occupation:*_____ *Father's Occupation:*_____
Parents are: ☐ *Married* ☐ *Separated* ☐ *Divorced*
Living with: ☐ *parents and sibling* ☐ *foster home*
List names and ages of brothers and sisters:

Were you referred to us by your family physician (or pediatrician)? ☐Yes ☐ NO
If no, how did you hear about us?

Referring Physician Name:	Phone Number:
Address:	
Family Physician: *(leave blank if same as referring)*	Phone Number:
Address:	
Pharmacy Name:	Pharmacy Phone #
Pharmacy Address:	

We would like to send a report of your eye exam to all physicians who care for you (or your child). Please indicate here if you prefer that we do not send a report to any of the above physicians:

List of EYE DROPS:

Name	Dosage	Why being used?

List of MEDICATIONS:

Name	Dosage	Why being used?

ALLERGIES:

EYE HISTORY:

Yes	No	Glasses/Contact Lenses/Prisms	
		Glasses	How old is your current pair?
		Contact Lenses: *(circle below)* Hard, Gas Permeable or Soft?	How old is your current pair? Contact Lens Cleaning Solutions:
		Prisms	How long?

Please Check Which Apply:

Yes	No	Age or How Long?		Yes	No	Age or How Long?
		Eye Exam				Eye Injury
		Patching				Stye
		Eye Exercises				Recurring “Pink Eye”
		Eye Muscle Surgery				Cataract
		Other Eye Disease:				Glaucoma
						Diabetic Eye Exam

Recent Eye Symptoms:

Yes	No	How long?		Yes	No	How long?
		Crossed or Wandering Eye				Drooping Eye Lid
		Excessive Squinting				Tired Eyes when Reading
		Double Vision				Dry or Gritty Sensation
		Excessive Eye Rubbing				Itching Eyes
		Frequent Tearing or Discharge				Red Eyes
		Blurred Vision				Flashing Lights or Floaters
		Light Sensitivity				Poor Peripheral Vision
		Other Eye Symptoms:				

MEDICAL HISTORY:

Yes	No	Condition		Yes	No	Condition
		Frequent Ear Infections				Diabetes
		Sinus Disease				Insulin Dependent Diabetes
		Heart Disease				Kidney Disease
		High Blood Pressure				Neurologic Disease
		Asthma				Seizures or Stroke
		Other Lung Disease				Depression
		Arthritis				Cancer
		Thyroid Problem				Anemia
		Other Major Illnesses				

Other Recent Symptoms:

Yes	No	How Long?		Yes	No	How Long?
		Weight Loss				Diarrhea/Constipation
		Excessive Fatigue				Frequent & Painful Urination
		Fever				Blood in Urine
		Earaches				Muscle Weakness
		Sore Throat				Rash
		Dry Mouth				Headaches
		Chest Pains				Dizziness
		Palpations				Numbness
		Shortness of Breath				Paralysis
		Swelling of Hands/Feet				Memory Loss
		Loss of Appetite				Change in School Performance
		Vomiting				Clumsiness

List previous surgeries not mentioned above:

FAMILY EYE HISTORY (Circle family member that have or had the same.)

Yes	No	Glasses before age 6	Father	Mother	Sister	Brother	Other
Yes	No	Amblyopia	Father	Mother	Sister	Brother	Other
Yes	No	Patching Treatment	Father	Mother	Sister	Brother	Other
Yes	No	Strabismus (crossed or wandering eyes)	Father	Mother	Sister	Brother	Other
Yes	No	Eye Muscle Surgery	Father	Mother	Sister	Brother	Other
Yes	No	Cataracts	Father	Mother	Sister	Brother	Other
Yes	No	Glaucoma	Father	Mother	Sister	Brother	Other
Yes	No	Blindness (why?)	Father	Mother	Sister	Brother	Other
Yes	No	Eye Injury	Father	Mother	Sister	Brother	Other
Yes	No	Eye Disease Caused by Diabetes	Father	Mother	Sister	Brother	Other
Yes	No	Macular Degeneration	Father	Mother	Sister	Brother	Other
Yes	No	Retinal Detachment	Father	Mother	Sister	Brother	Other
Yes	No	Other Serious Eye Disease in childhood	Father	Mother	Sister	Brother	Other
Yes	No	Other Eye Disease:	Father	Mother	Sister	Brother	Other

FAMILY MEDICAL HISTORY (Circle family member that have or had the same.)

Yes	No	Complication of Anesthesia	Father	Mother	Sister	Brother	Other
Yes	No	Genetic Disease (runs in family)	Father	Mother	Sister	Brother	Other
Yes	No	Heart Disease	Father	Mother	Sister	Brother	Other
Yes	No	Diabetes	Father	Mother	Sister	Brother	Other
Yes	No	High Blood Pressure	Father	Mother	Sister	Brother	Other
Yes	No	Stroke	Father	Mother	Sister	Brother	Other
Yes	No	Cancer	Father	Mother	Sister	Brother	Other
Yes	No	Other Serious Illness in Family Members:	Father	Mother	Sister	Brother	Other

BIRTH HISTORY (<u>Pediatric Patients ONLY</u>): *Birth Weight:_____ lbs_____oz*

Yes	*No*	*Condition*	*Describe:*
		Problem during pregnancy	*Describe:*
		Problem during delivery	
		Cesarean delivery	
		Delivered early or late	*How many weeks?*
		Baby kept in hospital due to illness	*Why and how long?*
		Delayed development	*Describe:*

Thank you for completing. We look forward to taking caring of your eyes!

Mudgil Eye Associates PATIENT REGISTRATION & OFFICE POLICY FORM

CONSENT TO TREAT: By signing this form, I consent to and authorize Mudgil Eye Associates to treat me. I understand, this could include diagnostic tests and imaging studies in addition to an ophthalmic exam. I understand I have the right to refuse treatment.

RELEASE & ASSIGNMENT OF BENEFITS: I hereby authorize the release of any medical information necessary to process the insurance claim for surgical and or medical services provided to my dependent or me. I further authorize payment of medical benefits directly to Mudgil Eye Associates.

INSURANCE COVERAGE: I understand it is my responsibility to be familiar with my insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. I accept full financial responsibility for all services and products I receive. I understand that this authorization may not result in full payment by my insurance carrier for the charges incurred, and I agree that I am financially responsible to make payments in full on the remainder balance if my insurance carrier determines the services I received are not covered, unless otherwise prohibited by state or federal regulations.

REFERRAL: I understand it is my responsibility to obtain the referral prior to my visit. If there is no referral on file at the time of the visit, I will be personally responsible for the full cost of the visit. I also understand, if I do not have a current referral on file, I may be asked to reschedule the appointment.

FINANCIAL RESPONSIBILITY: I understand copays, deductibles and/or coinsurance are due at the time of service or promptly paid when billed. There will be a $15 service charge if co-pay, coinsurance or deductible is not paid at the time of the service. We accept cash or credit card as forms of payment. There will be $35 bounced check processing fee. Non-payment for services received may result in collections and/or discharge from the practice.

I understand that there may be services that I receive that may be non-covered or not considered reasonable or necessary by Medicare or other insurers. For example, **REFRACTION** is a procedure necessary for the eye doctor to evaluate your vision and prescribe glasses. Although an important part of your exam, it is excluded from Medicare and many medical insurance plans. We are required to charge you a refraction fee separate from your exam. Payment for non-covered services must be paid at the time of your visit. Self-pay patients must pay in full at the time of service.

Mudgil Eye Associates does not get involved in domestic/custody disputes. Payment must be made by the guardian/parent bringing the child at the time of the visit.

CONTACT LENS "FITTING": I understand that contact lens "fitting" is not included in a complete eye exam; it is a separate procedure with an additional charge. Payment for fitting will be expected at the time of the service.

MISSED APPOINTMENTS: I value the time set aside by Mudgil Eye Associates to see and treat me and/or dependent. I will notify them no less than 24 hours before my appointment if I am unable to make it to my appointment. I will be charged $69 "no show" fee for not showing up to my appointment. Repeat missed appointments may result in discharge from the practice.

PATIENT AUTHORIZATION: I authorize Mudgil Eye Associates PC to share copies of my records with other physicians as needed for continuity of care. I understand that this is a group practice and other eye doctors may be involved in my eye care. I agree and understand a copy of my medical records including HIV AIDS, behavioral health service, psychiatric care, and treatment for alcohol or drug use will be included as part of my health information. I also agree that Mudgil Eye Associates PC may release my records to crediting or regulatory agencies when those agencies request my records and if law permits.

AUTHORIZATION TO COMMUNICATE PRIVATE HEALTH INFORMATION/HIPAA: *I acknowledge that I have been offered HIPAA NOTICE OF PRIVACY PRACTICES for Mudgil Eye Associates, PC and that I authorize the use and disclosure of my health information. I authorize Mudgil Eye Associates to leave messages on my answering machine, Voicemail or with individuals who attend my Primary Phone# or Secondary Phone# on the patient registration form.*

Mudgil Eye Associates will share my private health information with family or other members it feels is important and in my best interest to share appointment or eye care information. This means they will answer family member's questions and confirm appointment information if the inquiry is made on behalf of the patient. If you do not agree with our policy, please provide the names of individuals who may answer your phone and with whom we should not share your information _____.

PATIENT'S INFORMATION

Last Name	First	MI	Date of Birth

Address	City	State	Zip

Primary Phone#	Secondary Phone#	Email Address:

Gender: ( ) Male ( ) Female	Marital Status ( ) Married ( ) Single	Social Security#	Occupation

Employers Name & Address	Work Phone#

PRIMARY INSURANCE

Insurance Name		Policy# / Member ID	
Policy Holder's Name	**DOB**	Relationship to Patient	Social Security#
Policy Holder's Address (if different than patient)	City	State	Zip

SECONDARY INSURANCE

Insurance Name		Policy# / Member ID	
Policy Holder's Name	**DOB**	Relationship to Patient	Social Security#
Policy Holder's Address (if different than patient)	City	State	Zip

GUARANTOR'S INFORMATION–*pediatric patients only*

Guarantor's Name	Relationship to Patient	Social Security#	DOB
Guarantor's Address (if different than patient)			

I understand that it is my responsibility to notify in writing any changes to this Authorization.

X _____ _____

Signature: Patient (Over 18)/Parent/Guardian's Signature **Date**