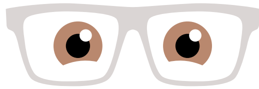


EYECARE
ASSOCIATES

WELCOME BACK TO OUR OFFICE

Name: ______________________________ Date of Birth: ______________________________

Mailing Address: ______________________________ SSN: ______________________________

City: ________________ Zip Code: ________ Employer: ______________________________

Phone Number: ______________________________ Occupation: ______________________________

Daytime Phone #: ______________________________ Marital Status: ______________________________

Cell Phone #: ______________________________ Spouse: ______________________________

Do you accept text messages? Yes or No Email: ______________________________

Date of last eye exam (if elsewhere) ____________________ Pregnant or Nursing: Yes or No

Who is your Primary Care Physician? ______________________________

What is the primary reason for your visit today? ______________________________

Do you wear contacts? Yes or No If no, would you like to try them? Yes or No

If yes, what brand? ____________________ Are you happy with your contacts? Yes or No

Medications: ______________________________

____

Allergies to Medications: ______________________________

Tobacco Use: Yes or No Current or Past If yes, how much? ________________

Please list any previous eye surgeries: ______________________________

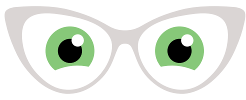
Please list if you or a relative have ever been diagnosed or treated for the following:

Ocular History	Relationship	Medical History	Relationship
Cataracts	________	Allergies	________
Corneal Problems	________	Asthma	________
Diabetes	________	Cancer	________
Dry Eyes	________	Cholesterol	________
Eye Injuries	________	Migraines	________
Flashes of Light	________	High Blood Pressure	________
Glaucoma	________	Lupus	________
Macular Degeneration	________	Stroke/TIA	________
Ocular Allergies	________	Hepatitis A B C (circle one)	________
Double Vision	________	Kidney Disease	________
Cross/Eye turn	________	Multiple Sclerosis	________
Floaters	________	Tuberculosis	________
Retinal Issues	________	Thyroid (hyper or hypo?)	________
Other	________	Other	________

Signature of Patient or Guardian: ______________________________ Date ____________

Brian Mitchell, OD | Tessa Johnston, OD | Damon Hanson, OD

935 Royal Avenue, Medford, Oregon 97504 | Phone 541-779-2211 | Fax 541-779-8778 | www.EyeCareSouthernOregon.com



FINANCIAL RESPONSIBILITY

Patient's Name____ **Date of Birth** _______________
(Please print)

Cell Phone Number: ________________________________ **Texting ok? Yes or No**

Email Address (please print legibly)____

Mailing Address____

It is our office policy to inform you of our payment procedures. Please review and initial the section below that is applicable. **All accounts not paid within 60 days are subject to a 1.5% interest charge.**

Contact lens services fees are subject to additional fees that are not listed below.

________ 1. **Patient without Insurance (Private Pay)**

Please make payment for your care at each visit. If payment cannot be made at each visit, arrangement must be made with our billing department prior to your visit.

________ 2. **Patient with Insurance**

You are responsible for deductibles, co-pays, non-covered services (such as the **Optomap** which is $39), co-insurance, and items considered "not medically necessary" by your insurance company. Please pay co-payments and co-insurance amounts as services are rendered. The remaining balance should be take care of within one(1) month of notice from insurance company unless other arrangements are made with our billing department. If you or your insurance carrier make payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, notify the billing department to make other arrangements.

________ 3. **Medicare**

Our office will submite your Medicare charges to Medicare and your secondary insurance. You are responsible for deductibles, copays, and any non-covered services sush as the **refraction ($20)** and the **Optomap ($39)**.

I have read and agree to the financial policy information stated above that applies to me.

____ ______________________
Patient (or responsible party) signature Date

____ __________________________
Person signing on behalf of patient (please print name) Relationship to patient

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