

# WELCOME TO THE OFFICE OF DR. MITCHELL

Please take a few moments to print out, complete this form, and bring it to your office visit. Thank you.

Mr.  Mrs.  Ms.  Dr. Full Name \_\_\_\_\_ Nickname \_\_\_\_\_ Date \_\_\_\_\_  
 Street \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Sex M F Social Security \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Email Address \_\_\_\_\_ Work # \_\_\_\_\_  
 Spouse (or Parents) Name \_\_\_\_\_ Spouse (or Parents) Work # \_\_\_\_\_  
 Your Employer or School \_\_\_\_\_ Occupation \_\_\_\_\_  
 Vision Insurance \_\_\_\_\_ Health Ins. \_\_\_\_\_  
 Name of Insured \_\_\_\_\_ Date of birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Primary Care Physician \_\_\_\_\_ Phone number \_\_\_\_\_  
 Who May We Thank for Referring You? \_\_\_\_\_  
 Reason for your visit today? \_\_\_\_\_

**Your Medical History**

High Blood Pressure Yes No  
 Stroke Yes No  
 Thyroid Yes No  
 Cholesterol Yes No  
 Diabetes Yes No  
 Arthritis Yes No  
 Cancer Yes No  
 Do you Smoke? Yes No  
  
 Are you allergic to any medications? Yes No  
  
 List: allergies \_\_\_\_\_  
 \_\_\_\_\_  
  
 Date of Last Physical Exam \_\_\_\_\_  
 By Dr. \_\_\_\_\_  
 Date of Last Eye Exam \_\_\_\_\_  
 By Dr. \_\_\_\_\_  
 Other Medical Conditions \_\_\_\_\_  
 \_\_\_\_\_

**Current Medications ( Prescription or Over the Counter)**  
**Please List the Names of Your Medications**

Medications \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Eye Drops Yes No \_\_\_\_\_  
**Visual Needs (Circle all that apply, and list others)**  
 Skiing Sewing Contact Sports Reading Swimming Tennis Arts & Crafts Golf  
 Computer Cycling Basketball Fishing Hunting Racquetball Baseball House Repairs

**Family Medical History (please specify relationship to you)**

Blindness Yes No \_\_\_\_\_ Retinal Disease Yes No \_\_\_\_\_  
 Glaucoma Yes No \_\_\_\_\_ Macular Degeneration Yes No \_\_\_\_\_  
 Strabismus, Eye Turn or Lazy Eye Yes No \_\_\_\_\_  
 Diabetes Yes No \_\_\_\_\_  
 Heart Disease/ Stroke Yes No \_\_\_\_\_  
 High Blood Pressure Yes No \_\_\_\_\_  
 Other medical problems with family Yes No \_\_\_\_\_

Circle any Eye Conditions that Apply to You:

Distance Blur	Cataracts	Crossed Eyes	Light Sensitivity	Dry Eye	Eye Diseases _____
Near Blur	Glaucoma	Lazy Eye	Burning/Redness	Tearing Eyes	Drug Sensitivities _____
Floaters	Eye Injury	Patching	Headaches	Itching Eyes	Other _____
Flashing Lights	Double Vision	Eye Surgery	Vision Therapy	Eye Surgery _____	

Do you wear contacts?	Yes No	Brand of contacts _____
Are you satisfied with your current brand?	Yes No	How many hours have your contacts been in today? _____
Are you interested in wearing contacts?	Yes No	Average Wearing Time _____
Are you interested in sunglasses?	Yes No	Age of Contacts in Eyes _____
Is there ever a time you'd like to see without glasses?	Yes No	Solution Used? _____
Are you ever bothered by the weight of your glasses?	Yes No	When Cleaned? _____ # of seconds? _____
Are you ever bothered by glare?	Yes No	
Would you like information on Laser Vision Correction?	Yes No	

**WELCOME TO OUR OFFICE!**

We provide the highest quality professional eye and vision care for our patients. In return for our uncompromising standards and service, we ask that our patients keep their accounts current. Please read, initial and sign the following **FINANCIAL POLICY**. If you have any questions please feel free to ask.

**Patients are expected to pay in full at the time services are rendered, or eyewear is ordered.** We accept Visa, MasterCard and Discover to aid in your budgeting of expenses. You are responsible for paying your account in full within 30 days, even if you have not returned to pick up your eyewear. After 30 days, balances are considered delinquent, and are subject to a billing charge of 1.5% per month (18.12% per year). There is a \$30 fee for checks returned by your bank for insufficient funds. Patient accounts with outstanding balances past 90 days are turned over to our collection service. We appreciate your notifying us at least 48 hours in advance if you should need to change your appointment with us. Appointments missed without a minimum of 24 hours advance notice are subject to a cancellation fee.

\_\_\_\_\_  
Initial

**If you have vision coverage for routine eye examinations or medical coverage for problem visits with a company with which we have an agreement (Vision Service Plan, Aetna, CIGNA, BCBS, others) AND you bring us a current insurance card on the day services are received, we will gladly accept contracted payments directly from your plan.** Routine eye examinations result in prescriptions for eyeglasses; contact lens examinations incur additional fees, and are not usually covered by your insurance. Likewise, medical conditions such as "lazy eye," diabetes or headaches, may necessitate additional medical tests beyond the scope of your vision coverage or initial referral form. Copayments and overages are due on the day services are received and materials ordered. **If you notify us after services are received, we will supply you with a coded receipt you can submit to receive reimbursement directly from your plan.** However, be aware that if we are not notified when services are rendered, your insurance company may only send you a partial reimbursement for services received. \_\_\_\_\_  
Initial

**When a health condition exists, the fees for medical testing can be submitted to your Major Medical insurance or Medicare (Major Medical and Medicare will not cover routine examinations, nor measurements taken for eye wear unless you have vision coverage).** If your visit might be covered under major medical, we will give you a coded receipt you can mail to your insurance company for reimbursement (for Medicare and some major medical plans we will submit the forms for you). The insurance company will reimburse *you* directly, not us, unless you are in a contracted plan. Please remember it is your responsibility to ensure all referral and certification procedures are followed. **These procedures may require a referral from your primary care physician, in which case you must bring the referral form, and your current insurance card on the day services are received, and pay any applicable copayments.** We cannot do this for you, as it comes from the office of your primary care physician. Without your insurance card and forms, you may receive only a partial reimbursement or no coverage at all. \_\_\_\_\_  
Initial

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. As required by "HIPPA", we have prepared a "Notice of Privacy Practices Policy". This explains how we are required to maintain the privacy of your health information and how we may use and disclose your health information. A copy of this policy is available to you at your request and on our website. \_\_\_\_\_  
Initial

Communication is the key to good relationships. Please feel free to ask any questions you have and we will be happy to help you.  
*The Staff and Doctors at the office of Mark G. Mitchell, O.D., F.A.A.O.*

**Please sign below:**  
With this signature on file, I am also permitting Dr. Mitchell's staff to submit my charges to my insurance company for reimbursement.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_