GLACIER EYE CLINIC

June 2021

Patient Information Sheet

General Information:

Last Name _____ First Name _____ Middle Initial _____

Mailing Address _____ City _____ State _____ Zip _____

Street Address _____ City _____ State _____ Zip _____

(If different from above)

Primary Phone: (____) ____-_____ ☐Cell ☐Home Alternate Phone: (____) ____-_____ ☐Cell ☐Home

Appointment Reminder Preference: ☐Text ☐Voice ☐No Reminder

Date of Birth: ___/____/____ Sex: _____ Email Address: _____

Social Security Number: _____-_____-_____ Marital Status: ☐Single ☐Married

Family Physician: _____ Referred by: _____

Emergency Contact Person: _____ Phone: (____) ____-_____ Relationship: _____

Employment Information:

Employer: _____ Occupation: _____

Employer Address: _____ Employer Phone: (_____) _____-_____

Insurance Information:

Insurance Company Name: _____ Subscribers Name: _____

Relationship to Subscriber: _____ Subscribers Date of Birth: ___/____/____

If Patient is a minor, please complete the following:

Parent/Guardian Name: _____ Relationship: _____

Parent/Guardian Address: _____

Parent/Guardian Phone: (_____) ____-_____ Parent/Guardian Date of Birth: _____/_____/_____

==========

IF YOU HAVE INSURANCE, WE WILL NEED TO COPY YOUR INSURANCE CARD.
WE ARE UNABLE TO BILL YOUR INSURANCE WITHOUT A COPY OF YOUR CARD.

==========

Information regarding DILATING DROPS: Dilating drops are used to dilate or enlarge the pupils of the eye to allow the doctor to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bring lights bothersome. It is not possible for your doctor to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, you may need to wait for your eyes to adjust before driving or arrange for a driver. Adverse reaction, such as acute angle closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. By signing below, I authorize Glacier Eye Clinic to administer dilating eye drops. I understand the eye drops are necessary to diagnose my condition.

RELEASE: I affirm that the information I have given is correct to the best of my knowledge and that I am responsible to inform this office of any changes. I authorize Glacier Eye clinic to administer dilating drops. I understand that I am responsible for all fees regardless of insurance benefits. I authorize the release of any medical information necessary to process my claims. I authorize the payment of medical benefits directly to the physician for services performed.

SIGNATURE: _____ DATE: _____

Glacier Eye Clinic, P.C.

175 Timberwolf Parkway, Kalispell, MT 59901 406-257-2020

ACKNOWLEDGMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Clinic Notice of Privacy Practices. I understand that the Notice of Privacy Practices describes how Clinic may disclose and use my protected health information.

Patient Name: _____ Patients DOB: _____

Signature: _____ Date: _____

If signed by the patient's personal representative, indicate:

a. Name of signer and relationship to patient

If acknowledgment not signed, indicate reason not signed and efforts made to have acknowledgment signed:

_____

_____

_____

AUTHORIZATION TO DISCUSS MY CARE

I, _____would like to give authorization to this facility to discuss my medical care with the following persons. I understand this authorization will stay in effect until I ask to have it removed in writing.

Individual(s) Name:	Relationship to Patient:
_____	_____
_____	_____
_____	_____

Can we Leave a Message?

Home Phone: _____ OK to Leave Message Y or N

Cell Phone: _____ OK to Leave Message Y or N

GLACIER EYE CLINIC, P.C.
175 Timberwolf Parkway Kalispell, MT 59901 406.257.2020 FAX 406.257.5554 www.glaciereyeclinic.com

Medical Questionnaire

NAME: _____ Date _____

Do you ***currently*** have any problems in the following areas? If YES, please **circle & provide additional information.**

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT(hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY **(Mother, Father, Grandparent, Sibling)**

Has any immediate member of your family had these diseases? (circle all that apply): YES NO UNKNOWN

Blindness, Cataract, Glaucoma, Macular Degeneration, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, or other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES NO**

Have you ever had a blood transfusion? **YES NO**

Do you use tobacco products? **YES NO** If YES, how much? _____ how many years? _____

Do you drink alcohol? **YES NO** If YES, how much? _____

PAST HISTORY

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, cancer, etc.) or **injuries** (concussion, etc.) _____

_____

List any **surgeries** you have had (cataract, appendectomy, etc.)_____

_____

Tech initial/date:

_____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

GLACIER EYE CLINIC, P.C.

175 Timberwolf Parkway, Kalispell, MT 59901

406-257-2020

MEDICATION LIST

DATE: _____ NAME: _____ BIRTHDATE: _____

ALLERGIES AND REACTIONS: _____

_____

PHARMACY NAME: _____

Medication Name	Strength/ Milligrams	By Mouth or Injection	Dosage/ How Many times per day

HERBS/VITAMINS			

TECH INITIAL/DATE

IMPORTANT PAYMENT INFORMATION ABOUT REFRACTIONS AND ROUTINE VISION CARE

One of the most important parts of your eye exam today is the refraction. Refraction is simply an eye test performed that measures a patient's prescription for eyeglasses or contacts. Additionally, it is the most precise way we can determine what your best possible visual acuity is, which is essential information as we examine your eyes for possible problems and diseases. Refractions are most often performed annually, however, the test may need to be done more frequently should there be a sudden change in vision requiring an updated prescription.

Refraction is the part of the examination where the doctor or staff member flips various lenses inside the phoropter and asks questions like "Better 1 or Better 2?" They will keep asking questions until they have helped you achieve the best possible corrected vision.

Refraction is NOT a covered service by Medicare, Medicare Advantage, and most other medical insurance plans. **The cost for refraction is $35.00 and is due from you at the time the service is provided to you.** It is in addition to any copayment, deductible, coinsurance your plan may require.

You may have coverage for refraction and/or routine vision care through a separate vision plan distinct from your medical plan. Examples may include, but are not limited to: Eyemed, VSP, Davis Vision, BlueVision, etc. ***Glacier Eye Clinic is not contracted with any vision plans.*** You will be responsible for payment to Glacier Eye Clinic for refraction and routine vision care services, and will need to submit your vision plan eligible expenses directly to your vision plan. We can provide you with a copy of your paid itemized statement if your insurance requires you to do so.

Patient Signature_____ **Date**_____

Patient Signature_____ **Date**_____

Patient Signature_____ **Date**_____