Medical History Questionnaire

Name: _____ Date of Birth: _____ Date: _____

Date of Last Eye Exam: _____ Date of Last Medical Exam: _____ Primary Doctor: _____

Were you referred by your eye doctor or friend? If so, please list: _____

Please Attach a Medication List or use the space provided to List Current Medications					
Name of Medication	**Dosage**	**Frequency**	**Name of Medication**	**Dosage**	**Frequency**

PAST MEDICAL HISTORY - PLEASE CIRCLE ALL THAT APPLY

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Cancer: list type
_____
Chemo
COPD
Coronary Artery Disease
Depression
Diabetes type 1 or 2
End Stage/Renal Disease
GERD
Headaches
Hearing Loss
Hepatitis
High Blood Pressure
High Cholesterol
HIV/AIDS
Hyperthyroidism
Hypothyroidism
Leukemia
Lymphoma
Radiation Treatment
Seizures/Epilepsy
Stroke
Other: _____
_____

SURGERY/TRANSPLANT - LIST ANY SURGERIES YOU HAVE HAD

_____

_____

OCULAR HISTORY - PLEASE CIRCLE ALL THAT APPLY

Allergies
Cataracts
Cataract surgery - RT/LT
Contact Lenses
Dry Eyes
Eye Injury
Floaters
Glasses
Glaucoma
LASIK or other Eye surgery: _____
Lazy Eye
Macular Degeneration
Retinal Tear/Hole/Detachment
Other: _____

DRUG ALLERGIES/LATEX ALLERGY - PLEASE LIST ALL

Allergies: _____

FAMILY MEDICAL HISTORY - PLEASE CIRCLE WHAT BEST APPLIES TO YOUR FAMILY

MACULAR DEGENERATION
GLAUCOMA
BLINDNESS
DIABETES
OTHER EYE RELATED _____
OTHER _____

Do you use alcohol? _____ **Do you use tobacco? _____**

Current Occupation (Former if Retired): _____

Physician's Signature: _____Date: _____

PATIENT REGISTRATION FORM

Patient LEGAL name_____ **SEX**: M / F
First Middle Last

BIRTHDATE_____ **AGE**_____ **SSN** _____

MARITAL STATUS: Single / Married / Widow / Divorced / Other

ADDRESS _____

CITY _____ **STATE** _____**ZIP** _____

HOME (_____)_____ **WORK** (_____)_____ **CELL** (_____)_____

E-MAIL _____@_____

REFERRED BY _____ **PRIMARY CARE PHYSICIAN**_____

PERSON TO NOTIFY IN CASE OF EMERGENCY_____

RELATIONSHIP TO PATIENT_____ **PHONE** (_____)_____

INSURANCE INFORMATION

INSURANCE ASSIGNMENT AND RELEASE INCLUDING MEDICAL ASSISTANCE

I understand that I am personally liable for any charges not covered by my insurance company, including medical assistance. I also understand that this account and the charges incurred are my responsibility and if my medical coverage is pending, my account will be treated as a self pay account until I produce an active insurance. I hereby authorize **Lance K. Bergstrom, MD, Tracie Teig Malsom, OD and Emily Heinrich, OD** ; the doctor's billing company or staff to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions either via paper claim or electronically.

Responsible Party Relationship to Patient (if not patient) Date

MEDICARE AUTHORIZATION

I request the payment of authorized Medicare benefits be made on my behalf for any services furnished to **Lance K. Bergstrom, MD and Tracie Teig Malsom, OD and Emily Heinrich, OD.** I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If I have a secondary insurance company as I have indicated, my signature authorizes release of the information to the insurer or agency shown whether submitted by paper claim or by electronic means. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and I understand that I am responsible for any deductible and co-payment amounts. I also understand that some services may not be covered by the Medicare program and that I am responsible for payment of those services.

Medicare recipient's signature Date

CONT ON BACK

Bergstrom Eye and Laser Clinic

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please sign below: Our clinic will not share your personal information per HIPAA guidelines, unless other parties are listed below.

_____
Please Print Name

_____ _____
Signature Date

□ I am the only person authorized to obtain medical/financial records in any way.

OR

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION (This includes your spouse, children, care takers, etc.)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual refused to sign
- □ Communications barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please Specify)