TODD F. BIRCH, OD
JARED E. BIRCH, OD

SUMMIT EYECARE

CRAIG A. FLEMIING, OD
JAY L. BORGHOLTHAUS, OD

PATIENT INFORMATION

Today's Date:_____
Last Name:_____
First Name:_____ MI:_____
Date of Birth:_____ Gender:_____
Race:_____
Ethnicity:_____
Patient's SSN:_____
Address:_____
City:_____ State:_____
ZIP Code:_____
Home Phone:_____
Work Phone:_____
Cell Phone:_____
E-mail Address:_____
Employer:_____
Occupation:_____
Spouse's (or Parent's) Name:_____
Spouse's (or Parent's) Occupation:_____

FOR NEW PATIENTS ONLY

Who or what led you to choose our office for your vision care needs? _____

_____

INSURANCE INFORMATION

You are responsible for providing current, accurate insurance information in order for your insurance claim to be filed. We are happy to assist you in understanding your benefits.

Vision Insurance:_____
Subscriber Name:_____
Subscriber ID:_____
Subscriber DOB:_____
Medical Insurance:_____
Subscriber Name:_____
Subscriber ID:_____
Subscriber DOB:_____
Secondary Insurance:_____
Subscriber Name:_____
Subscriber ID:_____
Subscriber DOB:_____

The information you provide on this history form is critical to the evaluation of your vision and health. Complete both sides with total accuracy.

LIFESTYLE QUESTIONS

What is your preferred language?_____
What is the best way to contact you?_____

Do you…

☐ Work at a computer? How much? _____
☐ Have an interest in thinner, lighter lenses?
☐ Spend time outdoors? How much? _____
☐ Have sunglasses?
☐ Prefer to not wear your glasses?
☐ Want information about LASIK?
☐ Have more than one pair of prescription glasses?
☐ Have children?
☐ Have family members in need of eyecare?

Date of Last Eye Exam:_____
Name of Doctor:_____
Do you wear…? ☐ Glasses ☐ Contact Lenses
If yes, what type? _____
Solution used:_____

PATIENT SOCIAL HISTORY

☐ Check this box if you prefer to discuss this portion directly with the doctor.

Do you (please list frequency and type)…

☐ Drive? _____
☐ Use tobacco products? _____
☐ Drink alcohol? _____
☐ Use recreational drugs? _____

PATIENT EYE HISTORY

Have you experienced, been diagnosed with, or been treated for any of the following?

☐ Blurred Vision	☐ Burning
☐ Cataract	☐ Corneal Abrasion
☐ Lazy Eye	☐ Double Vision
☐ Eye Infections	☐ Eye Injury
☐ Light Flashes	☐ Floaters/Spots
☐ Glaucoma	☐ Grittiness
☐ Headache	☐ Iritis/Uveitis
☐ Itchiness	☐ Macular Degeneration
☐ Dry eye	☐ Retinal Detachment
☐ Tearing	☐ Poor Night Vision
☐ Vision Loss	☐ Eye Fatigue
☐ Discharge	☐ Foreign Body Sensation
☐ Stye or Chalazion	☐ Distortion/Halos
☐ Light Sensitivity	☐ Redness

☐ Other eye disorder:_____

PATIENT MEDICAL HISTORY

Primary Care Provider:_____

Location:_____

Date of Last Physical:_____

CURRENT MEDICATIONS (please list all prescription or over-the-counter medications you use, including eye drops, vitamins, and birth control):_____

_____

ALLERGIES (including seasonal and medication allergies):_____

_____

Have you experienced, been diagnosed with, or been treated for any of the following?

☐ Allergies	☐ Endocrine Disorder	☐ Constipation	☐ Multiple Sclerosis
☐ Cardiovascular Disease	☐ Crohn's Disease	☐ Genitourinary Disorder	☐ Brain Damage
☐ High Blood Pressure	☐ Thyroid Disorder	☐ Blood Disorder	☐ Epilepsy
☐ High Cholesterol	☐ Diabetes	☐ Anemia	☐ Psychiatric Disorder
☐ Stroke	☐ Hypoglycemia	☐ Skin Disorder	☐ Attention Disorder
☐ Heart Arrythmia	☐ Pituitary Disorder	☐ Rosacea	☐ Depression
☐ Constitutional Disorder	☐ Renal Disease	☐ Eczema	☐ Autism
☐ Fever	☐ Gout	☐ Musculoskeletal Disorder	☐ Dementia
☐ Chills	☐ Gastrointestinal Disease	☐ Arthritis	☐ Respiratory Disorder
☐ Weight Loss/Gain	☐ Nausea	☐ Muscle/Joint Pain	☐ Asthma
☐ Fatigue	☐ Vomiting	☐ Neurological Disorder	☐ Bronchitis
☐ Cancer	☐ Diarrhea	☐ Headache	☐ COPD/Emphysema

Use the space below to explain any condition marked above or any unlisted conditions that you may have:

_____

_____

_____

_____

SURGERIES (please list all systemic and ocular surgeries you have had):_____

_____

FAMILY MEDICAL/EYE HISTORY

Does a history of any of the following conditions exist in your family (please list relationship)?

☐ Blindness_____	☐ Diabetes_____
☐ Cataracts_____	☐ Heart Disease_____
☐ Corneal Problems_____	☐ High Blood Pressure_____
☐ Glaucoma_____	☐ Kidney Disease_____
☐ Lazy Eye_____	☐ Lupus_____
☐ Macular Degeneration_____	☐ Thyroid Disease_____
☐ Retinal Problems_____	☐ Cancer_____
☐ Other:_____	☐ Arthritis_____

I affirm that the information I have provided on this patient history form is accurate to the best of my knowledge.

Signature:_____ Date:_____

SUMMIT EYECARE

Insurance and Financial Policy

Thank you for choosing Summit Eyecare as your provider. We are committed to excellent patient care. The following is an explanation of our financial policy and agreement, which you must read and sign prior to any evaluation.

At Summit Eyecare, we believe that you deserve the best care. That's why we always present you with the best vision solution possible to treat your personal situation. Each year we provide outstanding vision care several hundred patients. Some of these patients have vision benefits, but some don't. If you have vision benefits, congratulations! You are very fortunate. Here are some important things that you should know:

INITIAL

_____ Your vision benefits are based upon a contract made between you and an insurance company. If you have questions regarding your vision benefits, please contact your employer or insurance company directly.

_____ We will bill your insurance as a courtesy to you. If insurance does not pay within 90 days, Summit Eyecare reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare, but it is important that you recognize that the insurance you have is a legal contract between you and your insurance company. Our office is not, and cannot be, a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

_____ In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. At times you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.

_____ You are responsible for knowing what services and materials your insurance covers and the providers and network(s) covered under your health insurance plan. Any service provided, but not covered by your insurance company, will be your responsibility to pay.

_____ Payment for optical material (i.e. glasses and contact lenses) is due in full at time of ordering.

_____ Insurance co-pays and deductibles must be paid at the time of service. After your insurance has determined benefits, any coinsurance amounts or non-covered services are the responsibility of the patient or responsible party.

I have read and agree to the above outlined financial policy of Summit Eyecare. I agree that I am ultimately responsible for any charges incurred at Summit Eyecare.

Patient/Responsible Party:_____ Date:_____

HIPAA Notice of Privacy Practices

This notice describes how protected health information about you may be used or disclosed and how you can get access to this information. Please review it carefully.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient/Responsible Party:_____ Date:_____

Persons, facility, or class of persons who are authorized to receive the records/information:

(Name)_____

SUMMIT
EYECARE
Your vision is our focus!

Which Location did you visit today? Date_____

☐ Idaho Falls – Merlin ☐ Idaho Falls – Pancheri ☐ Pocatello ☐ St. Anthony

Who may we thank for referring us? _____

Where have you learned about us? **(Select all that apply)**

- Media
  - ☐ Radio Ad - Station _____
- Phone Directory
  - ☐ Yellowbook
  - ☐ Dex – Qwest Directory
- Print Media
  - ☐ Post Register
  - ☐ Idaho State Journal
- Internet
  - ☐ Google.com
  - ☐ Yahoo.com
  - ☐ Bing
  - ☐ MSN.com
  - ☐ Facebook
  - ☐ Other _____
- Outdoor Media
  - ☐ Building Sign
  - ☐ Billboard
  - ☐ Automobile Advertisement
- Events
  - ☐ If Chukars
  - ☐ Open House
- Other
  - ☐ Please explain _____

Were you referred by your insurance company? ☐ Yes ☐ No
If referred by insurance agency, how were you referred?

- ☐ Website
- ☐ Agent
- ☐ Other _____

Did you visit our website before calling us? ☐ Yes ☐ No

What prompted you to choose us?

_____

_____

_____

_____