Patient Information

Dr. Todd Baumgartner, O.D.
Dr. Rebecca Barton, O.D.
Dr. Melissa Hinderschied, O.D.

Patient Information

Name:_____DOB_____SS#_____

Address:_____City:_____State_____Zip_____

Insurance _____Primary Insured _____

Contact Information (please circle (Primary) for the best daytime phone number)

Home_____ OK to leave a message? ___Yes ___No (Primary)

Work _____OK to leave a message? ___Yes ___No (Primary)

Cell _____OK to leave a message? ___Yes ___No (Primary)

E-Mail Address _____

Emergency Contact Name:_____ Phone _____

NOTICE OF PRIVACY

I have read/received a copy of Little Falls Eye Care Center Notice of Privacy Practices.

Signature of Insured/Guardian_____ Date _____

Medical History

Dr. Todd Baumgartner, O.D.
Dr. Rebecca Barton, O.D.
Dr. Melissa Hinderschied, O.D.

Name _____

Welcome to our office, and thank you for choosing us for your eye care needs. Please indicate below any conditions that apply to you by circling "yes" or "no".

Medical			**Please Describe**	**Medical**			**Please Describe**
Heart Disease	yes	no		Burning or Gritty or Dry	yes	no	
High Blood Pressure	yes	no		Itchy Eyes	yes	no	
High Cholesterol	yes	no		Tearing	yes	no	
Asthma/COPD/Emphysema	yes	no		Redness	yes	no	
Allergies/Sinus/Hay Fever	yes	no		Pain or Soreness	yes	no	_____
Stomach/Bowel	yes	no		Injury, Surgery	yes	no	_____
Skin Problems	yes	no		Other	yes	no	_____
Headaches, Migraines, ect.	yes	no		Glaucoma	yes	no	
Diabetes	yes	no		Cataracts	yes	no	
Thyroid or Other Glands	yes	no	_____	Macular Degeneration	yes	no	
Arthritis/Muscle/Joint Pain	yes	no	_____	Strabismus (lazy eye)	yes	no	
Cancer	yes	no	_____				

Eye				**Family History** Has any relative had the following:			
Blurred Vision	yes	no		Glaucoma	yes	no	_____
Sudden Loss of Vision	yes	no		Macular Degeneration	yes	no	_____
Double Vision	yes	no		Diabetes	yes	no	_____
Flashes/Floaters	yes	no		Other	yes	no	_____

Please list any surgical procedures within the last few years (include all eye surgeries):

_____

List Current Medications (or provide a copy): **Pharmacy:** _____

_____

Do you have any allergies to any medications? _____no _____yes, please list: _____

Last Physical Exam: _____ **Medical Doctor**: _____ **Last Eye Exam**:_____

Please list your: Height_____ **Weight** _____ **Blood Pressure** _____

Lifestyle

Do you or have you used tobacco? No/Previous/Current Occupation: _____

If student, grade & name of school_____

Do you wear glasses? ____yes ___no Do you wear contacts? ___yes ___no

Computer use: **Hours per day** _____ **Time Spent Outdoors**: **Hours per week** _____

Any concerns with glare or night vision? ____yes ____no Hobbies/Interests: _____

Financial Policy

Dr. Todd Baumgartner, O.D.
Dr. Rebecca Barton, O.D.
Dr. Melissa Hinderschied, O.D.

Little Falls Eye Care Center

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our financial policy. Ultimately, any and all financial liability rests with the patient/guarantor.

Our office participates with most major insurance plans. We provide medical as well as routine optometric care to our patients. We DO NOT participate with ALL vision plans. Benefits for eye exams are based on a patient's diagnosis. A DIAGNOSIS CAN NOT BE MODIFIED TO FIT YOUR PLANS BENEFIT. Therefore, if you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order to be covered under your medical insurance. If you do not have the proper referral and still wish to be seen, you will be asked to pay for your visit prior to seeing the doctor.

It is the patient's/ parent's/ legal guardian's responsibility to:

- Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
- Bring all of your current insurance cards to all visits.
- Provide our office with current information including address, phone numbers & employer.
- In accordance with your insurance contract you must be prepared to pay your co-pay at each visit. We accept cash, checks, Visa, Discover, and Mastercard.
- The patient / guarantor is responsible for all fees associated with the collection of any outstanding account balance. These fees will be added to your account.
- If for any reason a claim is denied due to incorrect insurance information supplied to our office by the patient / guarantor, the guarantor will be responsible for the account balance.
- Contact lens evaluations ARE NOT part of a routine eye exam; additional charges apply and must be paid the day of the contact lens exam. This charge is dependent on the type of lens required for your visual needs, charges range from $48 to $135 annually.

Payment is due in full at time of service. Any discount (insurance or promotional) on materials must be presented at the time of order to be valid. Material orders require deposit of one half at time of order and balance due at time of dispensing. Materials will not be released unless patient balance is zero. Any payment made by check that does not clear your bank account will result in a $30.00 return check fee, which will be added to your account and must be paid before the next visit.

For all services rendered to a minor/dependent patient, the parent/guardian accompanying the patient is responsible for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth, and social security number. We request that you inform the subscriber that their insurance has been used.

By signing below, I acknowledge that I have read and understand the above Financial Policy. I understand and agree I am financially responsible for all charges for services rendered. I hereby assign all insurance benefits to which I am entitled to Little Falls Eye Care Center. I authorize the use of this signature on all insurance claims. I authorize Little Falls Eye Care Center to release all information necessary to secure payment of benefits.

_____	_____	_____
Printed Name of Patient	Patient Social Security #	Patient Date of Birth
_____	_____	_____
Signature of Patient/Parent/Guarantor	Printed Name of Parent/Guarantor	Date