OFFICE USE ONLY:		
Dr: _____	ID #: _____	☐ Fundus Photos
Time: _____	INS: _____	☐ External Photos
Exam Type: _____	Copay: _____	Visual Field ☐ 10-2 ☐ 24-2
ROUTINE / MEDICAL	OPTOS: YES NO	☐ OCT (o) ☐ OCT(m)
RTC: ☐ Annual ☐ GLC ☐ IOP ☐ F/U ☐ _____		DFE Time: _____

Maine Mall Eye Care

New Patient Paperwork

If you were last seen in our office over 3 years ago, new paperwork is required.

Name: _____ **M F**

Birth Date: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Social Security #: _____

Occupation: _____

Preferred Name: _____ **Pronouns:** ☐He ☐She ☐They

Home Phone: _____

Cell Phone: _____ **Text: Y N**

Email: _____

Race/Ethnicity: _____

Primary Care Dr / Practice: _____

Do you wear glasses (including readers)? ☐ No ☐ Yes

Do you wear contact lenses? ☐ No ☐ Yes

REVIEW OF SYSTEMS

Last Eye Exam (mm/yy): _____

EYES
☐ Blurred vision
☐ Distortion of Vision
☐ Glare
☐ Light Sensitivity
☐ Haloes
☐ Infection of eyes/lids
☐ Frequent Styes
☐ Eye Pain / Soreness
☐ Watery Eyes
☐ Redness
☐ Itchy / Burning
☐ Dry Eye
☐ Foreign Body Sensation
☐ Sandy/Gritty Sensation
☐ Crossed / Lazy eye
☐ Glaucoma
☐ Macular Degeneration
☐ Retinal detachment
☐ Double Vision
☐ Loss of Vision
☐ Loss of side vision
☐ Floaters
☐ Flashes of Light
☐ Eye Fatigue

HEMATOLOGIC
☐ Anemia
☐ Bleeding Disorders

VASCULAR / CARDIO
☐ Heart Palpitations
☐ High Blood Pressure
☐ Vascular disease
☐ Heart Attack
☐ Cholesterol

EAR/NOSE/THROAT
☐ Dry Throat / Mouth
☐ Hearing Loss
☐ Chronic Cough

RESPIRATORY
☐ Asthma
☐ COPD
☐ Emphysema
☐ Sleep Apnea

GENTI-URINARY
☐ Kidney Issues / Failure
☐ Bladder Issues

GASTRO-INTESTIONAL
☐ Ulcerative Colitis
☐ Crohn's
☐ IBS / IBD

SKIN
☐ Growths/Rashes
☐ Psoriasis
☐ Rosacea

NEUROLOGICAL
☐ Headaches / Migraines
☐ Seizures
☐ Bell's Palsy
☐ Multiple Sclerosis

PSYCHIATRIC
☐ Anxiety
☐ Depression

ENDOCRINE
Diabetes (☐PRE ☐Type 1 ☐Type 2)
Year Dx: _____
Last A1C: _____
☐ Hyper / ☐ Hypo Thyroid
☐ Pituitary Gland Issue

BONE / JOINTS / MUSCLE
☐ Arthritis
☐ Rheumatoid Arthritis
☐ Muscle Pain
☐ Joint Pain
☐ Head or Neck Injury

ALLERGIC / IMMUNOLOGIC
☐ Lupus
☐ Cancer Type: _____
☐ Sjögren's Syndrome
☐ Allergies / Hay Fever

Have you ever been exposed to OR infected with:
☐ Gonorrhea ☐ TB
☐ Hepatitis ☐ Shingles
☐ HIV ☐ Syphilis

PREGNANT? ☐ No ☐ Yes

SOCIAL HISTORY
Tobacco Use: ☐ None ☐ Former
☐ Current (type/amount): _____
Alcohol Use: ☐ None ☐ Social
☐ Daily/Dependency ☐ Recovery
Narcotic Use: ☐ None ☐ Medicinal
☐ Recreational ☐ Dependency
Type: _____

EYE SURGERIES
☐ None ☐ **R** ☐ **L** ☐ **Both**
Surgery type: _____
Approx. Year: _____

OTHER (List Condition{s})
_____
_____

Continue to next page→

HEALTH HISTORY

Supplements/Vitamins: _____

Medications: _____

☐ **No Medications**

_____

Allergies: _____

☐ **No Drug Allergies**

FAMILY HISTORY

Please check off each item as it pertains to your parents, grandparents, siblings, children (living or deceased)

		If yes, state relation			**If yes, state relation**
Glaucoma	☐ Yes	_____	Diabetes	☐ Yes	_____
Macular Degeneration	☐ Yes	_____	Hypertension	☐ Yes	_____
Blindness	☐ Yes	_____	Cancer (type)	☐ Yes	_____
Crossed / Lazy Eye	☐ Yes	_____	Cardiovascular	☐ Yes	_____
Retinitis Pigmentosa	☐ Yes	_____	Thyroid Disease	☐ Yes	_____
Retinal Detachment	☐ Yes	_____	Lupus	☐ Yes	_____
Sjögren's Syndrome	☐ Yes	_____		☐ **Unknown History/Adopted**	

Other FHx (List Issue/Relation) ☐ Yes _____

optomap® ultra-widefield retinal imaging

"What is the optomap?"

The optomap is a digital image/photo of the retina (the back of your eye).

PLEASE CHECK ONE AND SIGN BELOW:

_____ **Yes,** I would like to have the optomap imaging today with my exam and I understand it is at an additional cost of $45.

_____ **No,** I do not want the optomap testing with my exam today.

Signature: _____ **Date**: _____

Does the doctor recommend this service?

Your doctor recommends having this test done at least every other year.

If you have a family history OR if you yourself have diabetes, pre-diabetes, glaucoma, macular degeneration or any other retinal issue, it is HIGHLY recommended to have the optomap done.

This is NOT covered by insurance as this is an elective test.

The **cost of the optomap is $45** due at the date of service.

Optomap and its benefits:

The Optomap is a panoramic image of the surface of the retina. This provides the doctor with a detailed look into your eyes and helps aid in monitoring and/or diagnosing certain health conditions, not just those related to the eyes such as diabetes, hypertension, heart disease, some cancers, and auto-immune disorders. Early detection could help save your vision or your life.

AUTHORIZED CONTACTS

Authorized person has access to: ☐ Appt info only ☐ Health & Appt info

Name/Relation to patient: _____

We are unable to discuss this information with anybody other than yourself without express consent.
(This will remain valid until it is requested that they be removed.)

Continue to next page→

Maine Mall Eye Care Policies & Procedures

Section 1. Financial Responsibility & Vision Care and Medical Insurance

By signing this form, you agree to pay the portion of the bill which is either not covered or denied by the insurance company. If you do not pay this amount, you are responsible for any collection fee assessed. MMEC reserves the right to refuse to submit claims to insurance companies we are not in network with. **It is your responsibility to know your insurance policy coverage and benefits. It is possible that our staff will not have access to all details of your benefits until the insurance claim has been submitted and processed**.
You are also responsible for obtaining any referrals required by your insurance company to be seen. When a medical diagnosis or medical condition is present that affects your eyes we must file the claim with your medical insurance, and the co-pays and deductibles for that insurance will apply. Vision insurances cover ONLY routine services/examinations and/or materials, any condition outside of routine can be deemed as medical and will be billed accordingly.
Additional visits to our practice following an initial visit are subject to additional charges (excluding contact lens checks and/or prescription checks within the first 90 days after the initial exam).
We offer a self-pay discounted rate of $195 for patients paying out of pocket ON THE SAME DAY OF SERVICE. This does NOT extend to patients whose provide insurance information after the date of service; at which point the full examination rate will be applicable.

Section 2. Patient Receipt of Privacy Notice

I hereby affirm that I have received a copy of the *Notice of Privacy Practices* from Maine Mall Eye Care. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this Notice from my healthcare provider. I understand that **my signature on this acknowledgement only signifies that I have received a copy** of the *notice* and does not legally bind or obligate me in any way. I understand that I am entitled to receive a copy of the *Notice of Privacy Practice* from my healthcare provider, whether I sign this acknowledgement or not.

Section 3. Contact Lens and Glasses Prescription information.

An annual contact lens exam and fitting are required to **renew** your prescription for contact lenses. The fitting fee is not covered by insurance. ***Contact lens follow ups are included with the fitting fee for 3 months following the initial exam date. Therefore, we recommend that annual renewal of contact lenses (contact lens fittings) be done AT the time of your annual visit. After such time, any subsequent visits and/or adjustments made to the contacts will require another exam.***
Training is required for all first-time lens wearers and there is an additional fee for this procedure. Your contact lenses are a medical device that can only be dispensed with a valid prescription. In office contact trials are for patients with appointments. If you run out of contacts before your scheduled contact lens exam, we can offer you trials ONE TIME ONLY. ***Unopened, unmarked contact lens boxes purchased from our office can be exchanged within 3 months of the purchase date.***
Glasses prescription follow ups are included in the cost of the exam fee for **three months from the exam.** After 3 months, a new exam is required.

Section 4. Maine Mall Eye Care Missed Appointment Policy

If you do not present to the office for your appointment at the designated time, this will be a “No-Show/Missed” appointment.
After the first “No-Show/Missed” appointment, you will receive a call or a letter reminding you of our "No-Show/Missed Appointment" policy. Our office staff will help you reschedule this appointment if needed.
If you have 2 “No-Show/Missed” appointments, you will receive a letter from our office advising you of the second no-show/missed appointment occurrence and the potential for a third occurrence will prevent you from scheduling any future appointments at our office.
If you have 3 "No-Show/Missed" appointments, you will receive a notice from our office stating that you may not be able to schedule any future appointments with our office. **You will receive a bill for a $35.00 missed appointment fee for any missed appointment.**

Section 5. IF PATIENT IS A MINOR (17 years old or younger) OR HAS A POA, THIS SECTION IS REQUIRED:

Guarantor's Name: (**REQUIRED IF PATIENT IS A MINOR**) _____

Relationship to Patient: _____

Guarantor's Address _____

Guarantor’s Cell Phone Number: _____

By signing this form, you are indicating that you have read, understand, and agree to the above information.

Signature: _____ Date: _____

Name (printed): _____