

Grendahl Eye Associates
Robin Grendahl, M.D.

DATE: _____

PLEASE COMPLETE AND RETURN TO OUR OFFICE

PATIENT NAME: _____ SOCIAL SECURITY: _____
ADDRESS: _____ SEX: _____ (M) _____ (F)
CITY: _____ STATE: _____ Date of Birth _____ Age _____
ZIP CODE: _____ MOTHER'S NAME: _____
PHONE (home): _____ FATHER'S NAME: _____
MOTHER'S WK PHONE: _____ GUARDIAN'S NAME: _____
FATHER'S WK PHONE: _____ DOCTOR: _____
E mail _____ REFERRED BY: _____

LOCAL CONTACT NUMBER (IF FROM OUT OF TOWN): _____
EMERGENCY CONTACT _____

Who is financially responsible?: _____

As a courtesy we will bill your medical insurance. You will be responsible for whatever your insurance does not pay. We are a medical provider and therefore we do not accept vision insurance. Please call us in advance if you have further questions.

PLEASE LIST THE FOLLOWING INSURANCE INFORMATION. WE WILL ALSO NEED A COPY OF THE CARD.

PRIMARY:

INSURANCE COMPANY: _____
INS. CO. ADDRESS: _____
ID NUMBER: _____ GROUP NUMBER: _____
FULL NAME, DATE OF BIRTH AND SOCIAL SECURITY NUMBER OF THE INSURED:

SECONDARY:

INSURANCE COMPANY: _____
INS. CO. ADDRESS: _____
ID NUMBER: _____ GROUP NUMBER: _____
FULL NAME, DATE OF BIRTH AND SOCIAL SECURITY NUMBER OF THE INSURED:

*** If Tricare or Alaska Native Health Service insures you, provide a letter of pre-authorization **BEFORE** you are seen.

PREFERRED PHARMACY _____

PLEASE SILENCE YOUR PHONE WHILE IN THE EXAM ROOM.

COMPREHENSIVE FAMILY, MEDICAL, MEDICATION, ALLERGY, SOCIAL & OCULAR HISTORY

Name _____ Date _____

What is the main thing that bothers you about your child's eyes or vision?

FAMILY MEDICAL HISTORY

- | YES | NO | |
|-----|-----|---------------------|
| () | () | CATARACTS |
| () | () | GLAUCOMA |
| () | () | CROSSED EYES |
| () | () | HIGH BLOOD PRESSURE |
| () | () | DIABETES |
| () | () | RETINAL DISEASE |
| () | () | MIGRAINES |
| () | () | BLINDNESS |
| () | () | AMBLYOPIA |
| () | () | RETINAL DETACHMENT |
| () | () | _____ |

PRESENT MEDICATIONS & DOSAGE

1. _____
2. _____
3. _____
4. _____
5. _____

USE BACK OF THIS SHEET IF MORE MEDS

ALLERGIES

CHILD'S MEDICAL HISTORY

- | YES | NO | |
|-----|-----|-------------------------------|
| () | () | HEPATITIS |
| () | () | HIV |
| () | () | CATARACTS |
| () | () | SINUS PROBLEMS |
| () | () | HIGH BLOOD PRESSURE |
| () | () | DIABETES |
| () | () | HEADACHES |
| () | () | CROSSED EYES |
| () | () | ARTHRITIS |
| () | () | GLAUCOMA |
| () | () | ASTHMA |
| () | () | STROKE |
| () | () | TUBERCULOSIS |
| () | () | THYROID DISEASE |
| () | () | HEART ATTACK |
| () | () | IRREG. HEART RHYTHM |
| () | () | CONGESTIVE HEART |
| () | () | SHORTNESS OF BREATH |
| () | () | ANGINA (CHEST PAIN) |
| () | () | LUPUS |
| () | () | ROSACEA |
| () | () | GOUT |
| () | () | PSORIASIS |
| () | () | SARCOIDOSIS |
| () | () | MENTAL/PHYSICAL
DISABILITY |
| () | () | MIGRAINES |
| () | () | AMBLYOPIA |

ADDITIONAL MEDICAL INFORMATION PERTINENT TO YOUR CHILD'S HISTORY :

ANY PAST EYE TRAUMA:(IF YES, PLEASE DESCRIBE THE TRAUMA)

PLEASE LIST THE MOST RECENT SURGERIES (WITH IN THE LAST 5 YEARS ,PLEASE LIST THE DATE AND DISCLOSE THE SURGERY)

DOES CHILD WEAR GLASSES? () YES () NO
IF YES,WHAT TYPE Distance () Reading () Bifocal()
HOW OLD ARE CHILD'S GLASSES? _____

PLEASE LIST LOCAL CONTACT IN CASE OF EMERGENCY

NAME: _____

ADDRESS _____

TELEPHONE: _____ OR CELL _____

**IF WE ARE DOING A NEW PATIENT OR YEARLY EXAM EYE EXAM
PLEASE EXPECT TO BE IN OUR OFFICE FOR 2 HOURS**

YOUR CHILD'S EYES WILL BE DILATED IN MOST CASES.

Dear Patient:

Your privacy is important to us. We need your permission to speak to anyone regarding your care and medications. Please list below any family members or healthcare providers who may contact us about your current medications or care. We will also need your signature at the bottom of this form giving us written permission to communicate with the individuals listed below.

_____	_____
_____	_____
_____	_____

I, _____, give Grendahl Eye Associates permission to discuss my current care and medications with the individuals or organizations listed above.

Witness: _____ Date: _____

NAME _____

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Grendahl Eye Associates, for services furnished me by GREENDAHL EYE ASSOCIATES. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services 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 other health insurance is indicated in item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. GREENDAHL EYE ASSOCIATES ,accepts the charge determination of the Medicare carrier as full charge ,and I am responsible only for the deductible ,coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. MEDIGAP: I understand that if Medigap policy or other health insurance in item 9 of the CMS-1500 form or elsewhere on other approved claim forms ,my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to GREENDAHL EYE ASSOCIATES,if possible or otherwise to me.

3. RELEASE OF INFORMATION: GREENDAHL EYE ASSOCIATES may disclose all or any part of my medical record and/financial ledger information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation(1) which is or may be liable or under contract to GREENDAHL EYE ASSOCIATES ,for reimbursement for services rendered, and (2) any health care provider for continued patient care. GREENDAHL EYE ASSOCIATES may also disclose on an anonymous basis any information concerning my case ,which is necessary or appropriate for the advancement of medical science, medical education, medical research ,for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. OTHER INSURANCE- I understand that GREENDAHL EYE ASSOCIATES maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that GREENDAHL EYE ASSOCIATES has no contract, expressed or implied,with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by GREENDAHL EYE ASSOCIATES if I belong to a plan that does not appear on the above mentioned list.

5. NON-COVERED SERVICES- I understand that GREENDAHL EYE ASSOCIATES contracts with health care service plans(ie HMO's PPO's) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services ,which are determined by the health care service plans not to be covered. Examples of non-covered services include ,but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with GREENDAHL EYE ASSOCIATES to obtain necessary health care service plan authorizations.

6. FINANCIAL AGREEMENT: I agree in return for the services provided to the patient by GREENDAHL EYE ASSOCIATES I will pay my account at the time service is rendered or will

make financial arrangements satisfactory to GREND AHL EYE ASSOCIATES for payment. If an account is sent to an attorney for collection,I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent,I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuing the patient,or any other party liable to the patient,is hereby assigned to GREND AHL EYE ASSOCIATES,if copayments and/or deductibles are designated by my insurance company orhealth plan,I agree to pay them to GREND AHL EYE ASSOCIATES. However,it is understood that the undersigned and or the patient are primarily responsible for the payment of my bill.

Signature or Authorized Party

Date