Eden Prairie Eye Care

Please note you can also access your paperwork and submit online at www.epeyecare.com

COVID SCREENING:

Our office has implemented new policies and procedures required to help reduce possible exposure to the Coronavirus please carefully read and respond to the following questions.

Have you tested positive for COVID-19 and/or waiting test results for COVID-19?

☐ No ☐ Yes - Please contact a team member prior to continuing this paperwork.

Please select any of the following if applicable:

- ☐ Fever
- ☐ Shortness of breath/Dry cough
- ☐ Runny nose
- ☐ Sore throat
- ☐ Sneezing
- ☐ Tearing, sinus pain/pressure that is unusual and not related to seasonal allergies
- ☐ New headache, New fatigue or weakness
- ☐ New loss of senses including taste and smell
- ☐ Travel to any foreign country within in the past month
- ☐ Travel within the United States within the past two weeks
- ☐ Been in recent contact with someone that has tested positive for COVID-19

☐ **I confirm that I am not experiencing any of the above symptoms**

Signature: _____ Date: _____

Appointment Disclosures:

Initial next to each statement.

Our office is taking as many precautions as possible for everyone's safety. If you have a weakened or compromised immune system, you could be at a greater risk of contracting COVID-19. If this is the case and you are not experiencing new ocular symptoms. We recommend rescheduling your routine appointment for a later date.

_____ **I have read the above statement and understand that if I am immunocompromised, I am at a greater risk for contracting COVID-19 and hereby do not hold Eden Prairie Eye Care or Dr. Oker accountable for possible exposure.**

Our goal is to provide a safe environment for our patients and for our staff. This section includes some important information we wish all of our patients to acknowledge prior to visiting our office. The COVID-19 is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You can contract COVID-19 from a variety of sources. The Coronavirus has a long incubation period. You or your healthcare provider may have the virus and not show symptoms, yet still be highly contagious. Determining who is infected by the Coronavirus is challenging and complicated. Due to frequency and timing of appointments, the characteristics of the virus and the location of our office, there is a risk of contracting the virus simply by coming to the facility. We are doing everything in our power to reduce the spread of the Coronavirus in our office including new policies and procedures.

_____ **I confirm that I have read the above notice and accept any risk of exposure to COVID-19 during my appointment. Furthermore, I recognize the highly contagious nature of this virus and acknowledge the possibility of exposure from other sources.**

_____ **I confirm that I have truefully answered the above questions to the best of my ability.**

Appointment Day Policies:

_____ **I understand that I will be required to wear a mask covering my mouth and nose for the entire duration of my appointment.**

_____ **I understand that my temperature will be taken upon entry of the facility. If my temperature is outside the normal range I will be asked to reschedule my appointment for another day.**

Signature: _____ Date: _____

Patient Information:

Name: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth:_____ Preferred Phone:_____ Occupation:_____

Email: _____ Refused **Preferred Contact Method: Email Text Phone**

Do we have permission to contact you for appointment reminders: Yes No

Whom may we thank for referring you to our office today?_____

HIPAA Privacy Acknowledgement (Brochure Available Upon Request):

- I authorize Eden Prairie Eye Care to share medical information to providers involved in my treatment.
- I acknowledge that I have been given the opportunity to read and/or receive Eden Prairie Eye Care's Notice of Privacy Practices and this authorization is to remain in effect until revoked by me in writing.
- The following listed person(s) have my permission to discuss medical and financial information on my behalf (optional): _____

PATIENT/GUARDIAN SIGNATURE:_____ **DATE:**_____

Medical and Vision Insurance Plan Policies:

- I understand that filing a medical/vision insurance plan is an additional service provided by this clinic.
- In the event that my plan determines that I am not eligible for coverage at the time of service, by signing this statement below, I hereby agree to be financially responsible for charges not covered by my plan.
- By signing below, I am requesting payment of authorized insurance benefits be made to Eden Prairie Eye Care for services furnished to me by the optometrist providing care at this clinic.

PATIENT/GUARDIAN SIGNATURE:_____ **DATE:**_____

Private Pay Patients:

- I have chosen the private pay option and decline insurance submission. I understand that payment is due for all services rendered on the date of service.

PATIENT/GUARDIAN SIGNATURE:_____ **DATE:**_____

Payment Policy:

- By signing below I am acknowledging that I am responsible for payments for services rendered in the event that my insurance does not cover them. In addition, all payment not submitted to insurance is due on the date of service. In the event that it is not collected or my insurance determines a balance is my responsibility, I will be billed a maximum of three times by mail. If no response is received, a $20 collection fee will be added to my account and the balance will be forwarded to a collection agency.
- I recognize that it is my responsibility to keep Eden Prairie Eye Care up to date with my current mailing address.

PATIENT/GUARDIAN SIGNATURE:_____ **DATE:**_____

Contact Lens Wearers:

- The cost for contact lens evaluations is between **$59.00 and $79.00.** Any follow up visits and trial contact lenses required for this process will be included in this fee within the 90 day fit period.
- All new contact lens wearers will be required to complete a contact lens insertion and removal class in office and are charged an additional fee of **$25.00.**
- **New Patients:** Please tell us about your lenses here: **Do you sleep in your lenses? ☐ Yes ☐ No**
- **Brand:**_____ **Prescription: RT:**_____ **LT:**_____
- I have read these statements and wish to proceed with a contact lens evaluation during today's visit:

PATIENT/GUARDIAN SIGNATURE:_____ **DATE:**_____

Retinal Evaluation:

- In response to COVID-19 and due to safety concerns, this office is temporarily not performing routine dilated fundus examinations. This service will be provided on an as needed/urgent basis only. We instead are requiring digital retinal images utilizing the iWellness with Optomap Technology at every routine eye exam. In the event that your insurance does not cover this service (most plans do not) there will be an additional $30.00 copay required for the examination due on the service date.
- I have read the above statement and agree to the required **$30 copay** for this service.

PATIENT/GUARDIAN SIGNATURE:_____ **DATE:**_____

Medical History Questionnaire:_____

Name:_____ Date of Last Eye Exam:_____ Today's Date:_____

What is the primary reason for your visit today? _____

Medications (if name is unknown list what they are taken for): _____

_____

_____ ☐ No Current Medications

Allergies to Medications: ☐No ☐Yes list here: _____

Surgeries (non ocular): _____

Check any of the following applicable personal ocular conditions: ☐ Eye Injury ☐Cataract ☐Keratoconus ☐Macular Degeneration ☐Glaucoma/Suspect ☐Retinal Hole/Detachment ☐Strabismus/amblyopia (lazy eye)

☐ **Eye Surgeries**: ☐ Cataract ☐ PRK/LASIK ☐ Glaucoma ☐ Diabetic Retinopathy ☐ Eye Muscle ☐ Lid

Review of Systems:_____

Eyes:	☐ Dry Eye ☐ Redness ☐ Burning ☐ Itching	☐ Tearing ☐ Discharge ☐ Blurred Vision ☐ Eyestrain	☐ Eye Pain ☐ Light Sensitivity ☐ Headache (new) ☐ Poor Night Vision	☐ Night Glare ☐ Double/Loss of Vision ☐ Floaters (new) ☐ Flashes of Light

Existing Patients Only: If there are no changes with the information below initial _____ and skip this page

General	☐ Developmental Disabilities ☐ Fatigue Syndrome ☐ Cancer Type:_____ ☐ Other:	**Psych**	☐ Depression ☐ Attention Deficit ☐ Anxiety Disorder ☐ Bipolar Disorder ☐ Other:	**Gastro-Intestinal**	☐ Crohn's ☐ Colitis ☐ Ulcer ☐ Acid Reflux ☐ Celiac Disease ☐ IBS ☐ Other:	**Skin**	☐ Eczema ☐ Rosacea ☐ Psoriasis ☐ Cold Sores ☐ Shingles Location:_____ ☐ Other:
Ear Nose Throat	☐ Hearing Loss ☐ Sinusitis ☐ Dry Mouth ☐ Laryngitis ☐ Other:	**Cardio-Vascular**	☐ Hypertension ☐ Stroke/CVA ☐ Heart Disease ☐ Vascular Disease ☐ Congestive Heart Failure ☐ Other:	**Gastro-Urinary**	☐ Kidney Disease ☐ Prostate Cancer ☐ Herpes ☐ Chlamydia ☐ Benign Prostate ☐ Currently Pregnant ☐ Currently Nursing ☐ Other:	**Endocrine**	☐ Diabetes Type 2 ☐ Diabetes Type 1 ☐ Thyroid Disorder ☐ Hormonal Dysfunction ☐ Other:
Neuro	☐ Multiple Sclerosis ☐ Epilepsy ☐ Cerebral Palsy ☐ Tumor ☐ Stroke/CVA ☐ Migraine ☐ Autism ☐ Other:	**Lungs**	☐ Tobacco Use ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ COPD ☐ Sleep Apnea ☐ Other:	**Musculo-Skeletal**	☐ Osteoarthritis ☐ Arthritis ☐ Fibromyalgia ☐ Muscular Dystrophy ☐ Ankylosing Spondylitis ☐ Osteoporosis ☐ Gout ☐ Other:	**Blood Lymphatic**	☐ Anemia ☐ High Cholesterol ☐ Large Volume ☐ Blood Loss ☐ Other:

Allergic Immune	☐ Environmental Allergies ☐ Rheumatoid Arthritis	☐ Lupus ☐ Sjogren's Syndrome	☐ HIV ☐ Other:

Social History:_____

Does your vision limit any activities (driving, reading, sports, work, ect) ? ☐ Yes ☐ No

Do you drink alcohol?☐No ☐Yes How much? _____ Do you smoke? ☐No ☐Yes How much? _____

Family History:	Cancer	Diabetes Type 1	Diabetes Type 2	Hypertension	Thyroid Dysfunction	Cataract	Macular Degeneration	Glaucoma
Father								
Mother								
Sibling								
Child								