MITCHELL REFRACTIVE SURGERY & EYE CENTER

Patient Information Sheet

PERSONAL INFORMATION

Patient Name: _____ DOB: _____

☐Dr. ☐Mr. ☐Mrs. ☐Miss. ☐Ms. ☐Other

Sex: ☐Male ☐Female ☐Decline To Specify

Street Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

OCULAR INFORMATION

Main reason for today's Examination: _____

Last Eye Exam: _____

Do you wear Glasses? ☐Yes ☐No IF YES: How old is your current pair? _____

Do you wear Contacts? ☐Yes ☐No IF YES: What Brand: _____

Are you under the care of an eye specialist for any eye conditions? ☐Yes ☐No

IF YES, who is the Doctor: _____ What for? _____

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

Policy Holder Information:

Name: _____ DOB: _____

Relationship to the patient: _____ Phone: _____

I UNDERSTAND AND AGREE THAT HEALTH/ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. I AUTHORIZE THE RELEASE OF PAYMENT FOR MEDICAL BEFITS TO MY PHYSICIAN AND ANY MEDICAL INFORMATION/RECORDS NECESSARY TO PROCESS MY INSURANCE CLAIMS. I WILL BE RESPONSIBLE FOR ANY CO-PAYMENT, DEDUCTIBLE, OR SERVICES NOT COVERED BY MY INSURANCE. IN THE EVENT THIS ACCOUNT NEEDS TO BE ASSIGNED TO A COLLECTION AGENCY OR ATTORNEY FOR COLLECTION, I AM AWARE THAT I WILL BE RESPONSIBLE FOR ALL ATTORNEY FEES, COLLECTION FEES, FILING FEES, FINANCE CHARGES, AND ANY OTHER COST INCURRED.

Signature: _____ Date: _____

If you are a SELF-PAY patient, payment is required at the time services are rendered.

Signature: _____ Date: _____

Mitchell Refractive Surgery & Eye Center

Alan L. Mitchell, M.D., P.A.

PATIENT NAME: _____

Due to Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out by each patient annually.

MARITAL STATUS (Circle One): Single/Married/Divorced/Widow(er)
ETHNIC GROUP (Circle One): Hispanic or Latino/ Not Hispanic or Latino/ Decline to Answer
RACE (Circle One): Black or African American/White/Asian American Indian or Alaska Native/Other

I authorize Alan L. Mitchell, M.D., P.A., to release any of my medical or insurance information necessary to process my medical claims and coordinate or manage my health care.

In the event a family member or caregiver attends office visits and is in the room with me, I give Dr. Alan L Mitchell and employees my permission to discuss freely, my condition, treatment, or diagnosis with that person. ◯ **YES** ◯**NO**

Please select PREFERRED contact number:

◯ **Home Phone: (_____) _____** **May we leave a message? YES/NO**

◯ **Work Phone: : (_____) _____** **May we leave a message? YES/NO**

◯ **Cell Phone: : (_____) _____** **May we leave a message? YES/NO**

Would you like to receive Appointment confirmations via TEXT MESSAGES? YES/ NO

Email: _____

By giving us your email address, you are giving us permission to contact you in that matter for appointments, offers, and clinical news (NO SPAM)

Primary Care Physician: _____ Phone: (_____) _____

Pharmacy: _____ Phone: (_____) _____ Crossroads: _____

PRIVACY (HIPAA) INFORMATION:

***Emergency Contact:** _____ Relationship: _____ Phone:(_____) _____

With whom may we discuss or release information about your care, treatment, or diagnosis?

SAME AS EMERGENCY CONTACT: ◯ **YES** ◯**NO**

Additional Persons:

Name: _____ Relationship: _____ Phone:(_____) _____

Name: _____ Relationship: _____ Phone:(_____) _____

CANCELLATION/NO-SHOW POLICY- Cancellations are requested 24-hours prior to your appointment. There will be a $30 charge for all cancelled appointments less than 24-hours and a $50 charge for No-Showed appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

TREATMENT OF STAFF - We take great pride in assisting our patients and providing exceptional patient care. If you or anyone representing you act in an abusive manner to a staff member or a Physician, you may be asked to leave and/or be discharged from the practice. We have a zero-tolerance policy for the mistreatment of our staff and Physicians so please be mindful of your behavior.

Signature: _____ **Date: _____**

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **Date:** _____

Date of Birth: _____

R= RIGHT, L= LEFT, B= BILATERAL

Past Medical History: (please circle all that apply and **provide the Diagnosis Date**)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes Type 2
Diabetes with Insulin
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement

None

Other: _____

Past Surgical History: (please circle all that apply, and **provide the Year of Surgery**)

Appendix Removed
Bladder Removed
Mastectomy (R/L/B)
Lumpectomy (R/L/B)
Breast Biopsy (R/L/B)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Knee Replacement (R/L/B)
Hip Replacement(R/L/B)
Joint Replacement w/in last 2 years
Kidney Biopsy
Kidney Removed (R/L)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (R/L/B)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

None

Other: _____

Ocular History: (please circle all that apply, and **provide the Diagnosis Date**)

Allergic conjunctivitis
Blepharitis
Cataract (R/L/B)
Corneal dystrophy (R/L)
Diabetic retinopathy, background (R/L)
Dry eyes
Glaucoma (R/L)
Macular degeneration (R/L)
Macular ERM (R/L)
Narrow angles (R/L)
Ocular hypertension (R/L)
Ophthalmic Migraine
Pseudo exfoliation
Retinal tear (R/L)
Strabismus
PVD (R/L)
Vitreous floaters (R/L)

None

Other: _____

Continue to the Back

Ocular Surgery: (please circle all that apply, and **provide the Year of Surgery**)

Blepharoplasty (R/L)
Cataract surgery (R/L)
Corneal transplant (R/L)
DSAEK (R/L)
Eye Muscle Surgery
Intravitreal injections (R/L)
LASIK (R/L)
LPI (R/L)
LTP (R/L)
PRK (R/L)
Ptosis repair (R/L)
Punctual plugs (R/L)
Strabismus surgery
Retinal laser(R/L)
Trabeculectomy (R/L)
Tube shunt (R/L)
Yag Capsulotomy(R/L)

None

Other: _____

Medications: (Please list all current medications with Dosage, and any Over-the-counter medication)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____
_____ _____

Eye Drops: (please list all eyes drops, including over the counter)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Vitamin Supplements: (Please list all vitamin supplements with dosage)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies: (Please list all drug allergies)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Social History: (Please circle all that apply

Cigarette Smoking:
- Never smoked
- Quit: Former Smoker, Date Quit: _____
- Smokes less than daily
- Smokes Daily

Alcohol Use:
- Alcohol: None
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Family History: (please circle all that apply, and familial relationship. Ex. Mother, Father, Sibling)

Blindness
Cancer
Cataracts
CVA
Diabetes
Glaucoma
Heart disease
Macular degeneration
Migraine
Retinal detachment
Strabismus

None

Other: _____

Have you had a Flu Vaccine this year? _____ If so, When? _____
Have you had a Covid Vaccine this year? _____ If so, When? _____

1. Questions about **EYE DISCOMFORT:**

a. During a typical day in the past month, **how often** did your eyes feel discomfort?

NEVER	RARELY	SOMETIMES	FREQUENTLY	CONSTANTLY
0	1	2	3	4

Select a number

b. When your eyes felt discomfort, **how intense was this feeling of discomfort** at the end of the day, within two hours of going to bed?

NEVER HAVE IT	NOT AT ALL INTENSE				VERY INTENSE
0	1	2	3	4	5

Select a number

2. Questions about **EYE DRYNESS:**

a. During a typical day in the past month, **how often** did your eyes feel dry?

NEVER	RARELY	SOMETIMES	FREQUENTLY	CONSTANTLY
0	1	2	3	4

Select a number

b. When your eyes felt dry, **how intense was this feeling of dryness** at the end of the day, within two hours of going to bed?

NEVER HAVE IT	NOT AT ALL INTENSE				VERY INTENSE
0	1	2	3	4	5

Select a number

3. Questions about **WATERY EYES:**

During a typical day in the past month, **how often** did your eyes look or feel excessively watery?

NEVER	RARELY	SOMETIMES	FREQUENTLY	CONSTANTLY
0	1	2	3	4

Select a number

Score:

1a	1b	2a	2b	3	TOTAL	0