

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

None

Other: _____

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

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

None

Other: _____

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

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

None

Other: _____

Continue to the Back



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

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

None

Other: _____

Heart disease

Macular degeneration

Migraine

Retinal detachment

Strabismus

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
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