MASON FAMILY VISION

PATIENT INFORMATION

Patient Name _____ **Gender** ☐ Male ☐ Female
Last First Middle

Preferred First Name _____ **Marital Status** ☐ Minor ☐ Single ☐ Married ☐ Widowed

Patient Home Address _____
Street Apt City State Zip

Phone Home_____ Work _____ Cell _____

Texting OK ☐ Yes ☐ No

Email_____

Patient DOB _____/_____/_____ **Age**_____ **Patient SSN** _____-_____-_____

Patient's Employer _____ **Occupation** _____

Emergency Contact _____
Name Relationship Phone

How did you hear of us? ☐ Physician Referral, if yes name of Physician _____

☐ Mail ☐ Internet ☐ Yellow Pages _____ Friend/Family Member _____ Other

In accordance with health care reform, please help our office report meaningful use measures:

Pref Language ☐ English ☐ Spanish **Communication Preference** ☐ Phone ☐ Postal ☐ Email

Race ☐ Asian ☐ Black/African American ☐ Hispanic ☐ Native Hawaiian/Other Pacific Islander ☐ White

Height _____ **Weight** _____

ADVANCE BENEFICIARY NOTICE: I understand that Medicaid does not pay for Retinal Imaging and Vision Therapy and Medicare does not pay for the refraction fee and both Medicaid and Medicare do not pay for contact lens evaluation fee.

INSURANCE INFORMATION

Do you have vision insurance?

☐ Yes ☐ No

Insurance Co _____
Policyholder Name _____DOB_____
ID#_____SSN_____

Do you have medical insurance?

☐ Yes ☐ No

Primary Insurance Co _____
Policyholder Name _____DOB_____
ID#_____SSN_____

Secondary Insurance Co _____
Policyholder Name _____DOB_____
ID#_____SSN_____

RESPONSIBLE PARTY

☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other _____

☐ Name/Address same as above
Name _____DOB _____
Address _____
Phone _____SSN_____

ASSIGNMENT AND RELEASE

I hereby state the information given is true and complete. I hereby authorize and request the payment of services from Medicare, Medicaid, and/or other insurance plans or payers be made on my behalf to Mason Family Vision, PC.

I hereby assign to Mason Family Vision, PC all payments for treatment services. I understand and agree that I am responsible for paying any amount not covered by Medicare, Medicaid, and/or other insurance plans or payers.

SIGNATURE _____ **DATE**___/_____/____

Today's Date:_____ Name of your primary care physician:_____

Your Name:_____ Date of Birth:_____

PAST MEDICAL HISTORY: CHECK ALL THAT APPLY

Do you now or have you ever had:

Systemic Conditions:

- ❑ High blood pressure
- ❑ Heart Disease
- ❑ High cholesterol
- ❑ Thyroid Disorder
- ❑ Diabetes (type I or II): A1C:_____
- ❑ Crohn's Disease
- ❑ Hepatitis
- ❑ Kidney Disease- Genitourinary
- ❑ Sexually Transmitted Disease
- ❑ Anemia
- ❑ Leukemia
- ❑ Sickle Cell Trait /Disease
- ❑ Tuberculosis
- ❑ Herpes Simplex /Zoster
- ❑ HIV/AIDS
- ❑ Sarcoidosis
- ❑ Psoriasis
- ❑ Rosacea
- ❑ Lupus
- ❑ Rheumatoid Arthritis
- ❑ Headache /Migraines
- ❑ Epilepsy (Seizures)
- ❑ ADD /ADHD
- ❑ Anxiety Disorder
- ❑ Depression /Bipolar
- ❑ Asthma
- ❑ COPD
- ❑ Sleep Apnea
- ❑ Cancer (type)_____

Please list any other medical issues:

_____

_____

Ocular Conditions:	**You**	**Family Member/Relation to Patient**
❑ Amblyopia or Lazy Eye	❑	❑_____
❑ Blindness Due to Disease	❑	❑_____
❑ Blindness Due to Injury	❑	❑_____
❑ Crossed or Turned Eye	❑	❑_____
❑ Diabetic Retinopathy	❑	❑_____
❑ Hypertensive Retinopathy	❑	❑_____
❑ Double Vision	❑	❑_____
❑ Flashes of Light	❑	❑_____
❑ Floaters or Spots in Vision	❑	❑_____
❑ Glaucoma	❑	❑_____
❑ Macular Degeneration	❑	❑_____
❑ Retinal Detachment or Tear	❑	❑_____
❑ Cataracts	❑	❑_____
❑ Other (please list)_____	❑	❑_____

DO YOU WEAR:

❑ Glasses (age of current pair):_____

❑ Contact Lenses (brand, if known)_____

Surgical History:	**Year:**	**Which Eye:**	**Performing Physician:**
❑ Cataract Surgery	_____	_____	_____
❑ Retinal Surgery	_____	_____	_____
❑ Eye Muscle Surgery	_____	_____	_____
❑ Traumatic Eye Injury	_____	_____	_____
❑ Lasik Surgery	_____	_____	_____
❑ PRK or RK Surgery	_____	_____	_____

❑ Any other major, non-eye surgery (please list below)

_____

Medications Taken:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medication Allergies:

_____

_____

_____

Food/Other Allergies:

_____

_____

Social History:

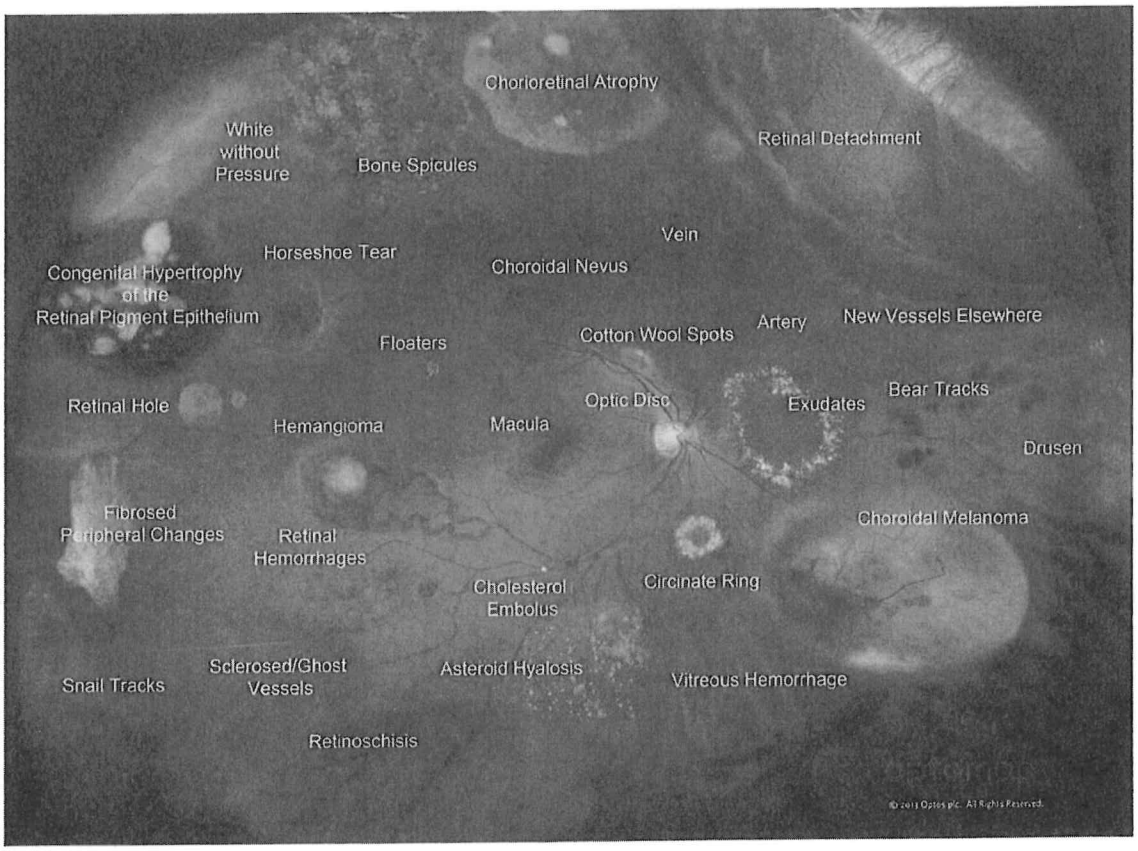
- ❑ Tobacco Use (per day)_____
- ❑ Alcohol Use(per day)_____
- ❑ Blood Transfusion (year)_____
- ❑ Pregnant (weeks)_____
- ❑ Nursing

MASON
FAMILY VISION

The optomap (digital image of the retina) will be done annually for every patient UNLESS a waiver is signed.

*Dr. Mason wants **ALL** patients to have a digital image of the retina annually with the new scanning digital imaging system. The test is only $39.*

Retinal problems such as macular degeneration, cancer, glaucoma, retinal holes, retinal detachments and diabetic retinopathy can now be seen without dilation for most patients.



Early detection is crucial!

Pre-Screen Questionnaire

1. Are you experiencing ANY of the following emergency symptoms: severe shortness of breath and difficulty breathing, persistent chest pain or pressure, new confusion or inability to arouse, bluish lips or face, loss of consciousness, slurred speech, and/or severe, constant dizziness or lightheadedness?
   - □ Yes
   - □ No

2. Are you experiencing any of the following symptoms? Please select all that apply.
   - □ Fever, chills or sweating
   - □ New or worsening cough
   - □ Fatigue
   - □ Body aches
   - □ Diarrhea
   - □ Reduced sense of smell and/or taste
   - □ Mild to moderate difficulty breathing
   - □ Sore throat
   - □ Runny nose
   - □ None of the above

3. Have you been told by a health official that you may have been exposed to COVID-19?
   - □ Yes
   - □ No

   If yes, give the date of most recent exposure: _____

4. Have you been around someone who is known to have COVID-19?
   - □ Yes
   - □ No

   If yes, give the date of most recent exposure: _____

5. Have you ever tested positive for COVID-19?
   - □ Yes
   - □ No

   If yes, explain and give dates: _____

6. Have you ever tested negative for COVID-19?
   - □ Yes
   - □ No

   If yes, explain and give dates: _____

7. Are you waiting for test results for COVID-19?
   - □ Yes
   - □ No

   If yes, explain and give dates: _____

Signature: _____ Date: _____