ISTHMUS EYE CARE

VISION SOURCE®

Date: _____ / _____ / _____

Patient's Name: _____

Address: _____

_____

_____

		Preferred
Home:	(_____) _____-_____	□
Work:	(_____) _____-_____	□
Cell:	(_____) _____-_____	□

Text Message Reminders: □ Yes □ No

Social Security #: _____-_____-_____

Date of Birth: _____/_____ /_____

E-mail Address:_____

For **ADULT** Patients:

Employer: _____

Occupation: _____

Spouse's/Partner's Name: _____

Spouse's/Partner's Occupation: _____

Names/Ages of Children at Home: _____

_____

_____

For **SCHOOL-AGED** Patients:

School Name: _____

Grade: _____

Parent/Guardian Name(s): _____

_____

Referred by: □ Person: _____ □ Insurance □ Internet/Website □ Other: _____

I understand the above information is necessary to provide me with ocular and vision care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. With my approval, I authorize the doctor to perform diagnostic procedures and treatments as may be necessary for proper ocular and vision care.*

*Consent in place until revoked from patient

Signature of Patient/Parent/Guardian: _____Date:_____/_____/_____

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ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received the chance to review a copy of the Isthmus Eye Care, S.C. Notice of Privacy Practices.

Patient Name____

Signature __________________________________Date_____________

I give consent to the release of any or all of my Isthmus Eye Care records to the following persons listed below that may need access to them.*

*Consent in place until revoked from patient

Name_____________________________Relation to patient_____________ Date__________

Name_____________________________Relation to patient_____________ Date__________

Name_____________________________Relation to patient_____________ Date__________

~ ~

I give consent to the release of any or all of my Isthmus Eye Care records through the online "Personal Health Records" portal to the following persons listed below that may need access to them and are current patients at Isthmus Eye Care.*

*Consent in place until revoked from patient

- ☐ Name: ____ Date__________
- ☐ Name: ____ Date__________
- ☐ Name: ____ Date__________

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ISTHMUS
EYE CARE
isthmuseye.com

To Whom It May Concern,

The patient below is in office for an appointment. Please **fax** an **updated medication list** as soon as possible. Our fax number is **(608) 831-8470**.

If you have any further questions, please call our office at (608) 831-3366.

Thank you,
Isthmus Eye Care

Patient Name:_____

DOB:_____

Clinic Location:_____

Clinic Fax Number:_____

Primary Care Physician:_____

Patient/Parent/Guardian Signature:_____Date:_____

7601 University Avenue
Middleton, WI 53562

P: (608) 831-3366
F: (608) 831-8470

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Review of Systems (Medical History): Please check if current or past medical conditions apply

Patient's History:

Are you currently pregnant and/or nursing: □ No □ Yes

Constitutional □ Negative
□ Developmental Disabilities
□ Cancer
□ Fatigue Syndrome
□ Other _____
Medications:

Eyes □ Negative
□ Glaucoma
□ Cataract
□ Age-related Macular Degeneration
□ Surgery
□ Patching Therapy
□ Inflammatory Disorders
□ Other _____
Medications:

Cardiovascular □ Negative
□ High Blood Pressure
□ Heart Disease
□ Vascular Disease
□ Congestive Heart Failure
□ Other _____
Medications:

Endocrinology □ Negative
□ Diabetes Type 1 (Insulin Dependant)
□ Diabetes Type 2 (Non-Ins Dependant)
□ Thyroid Dysfunction
□ Hormonal Dysfunction
□ Other _____
Medications:

Neurological □ Negative
□ Multiple Sclerosis
□ Epilepsy
□ Cerebral Palsy
□ Tumor
□ Stroke / CVA
□ Migraines
□ Other _____
Medications:

Integumentary (Skin) □ Negative
□ Eczema
□ Rosacea
□ Psoriasis
□ Cold Sores (h. simplex)
□ Shingles (h. zoster)
□ Other _____
Medications:

Ears/Nose/Throat □ Negative
□ Hearing Loss
□ Sinusitis
□ Dry Mouth
□ Laryngitis
□ Other _____
Medications:

Respiratory □ Negative
□ Cigarette Smoker
□ Asthma
□ Bronchitis
□ Emphysema
□ Chronic Obstructive Pulmonary Disease
□ Sleep Apnea
□ Other _____
Medications:

Musculoskeletal □ Negative
□ Osteoarthritis
□ Osteoporosis
□ Fibromyalgia
□ Muscular Dystrophy
□ Ankylosing Spondylitis
□ Gout
□ Other _____
Medications:

Gastrointestinal □ Negative
□ Crohn's Disease
□ Colitis
□ Ulcers
□ Acid Refux
□ Celiac Disease
□ Other _____
Medications:

Genitourinary □ Negative
□ Pregnant / Nursing
□ Kidney Disease
□ Prostate Disease / Cancer
□ Herpetic / Chlamydia
□ Other _____
Medications:

Hematology / Lymphatic □ Negative
□ Anemia
□ High Volume Blood Loss
□ High Cholesterol
□ Ulcers
□ Other _____
Medications:

Psychiatric □ Negative
□ Depression
□ ADHD
□ Anxiety
□ Bipolar Disorder
□ Other _____
Medications:

Allergy / Immunology □ Negative
□ Drug Allergies
_____
□ Environmental Allergies
_____
□ Lupus
□ Rheumatoid Arthritis
□ Sjogren's Syndrome
□ Other _____
Medications:

Family History: Please indicate family relation: Mother = M, Father = F, Brother = B, Sister = S, Other = O
Ocular: □ Glaucoma___ □ Age-related Macular Degeneration___ □ Cataract___ □ Other _____
Medical:□ High Blood Pressure___ □ Diabetes (Type 1/Type 2)___ □ Cancer___ □ Thyroid Conditions (Hyper/Hypo) ___
□ Other _____

Current Medications: List all medications including dosage (include oral contraceptives, aspirin, over the counter medications and home remedies)
□ See attached medication list

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Isthmus Eye Care Financial Policy

Payment Terms: Thank you for choosing Isthmus Eye Care for your eye care needs. We will require payment at the time of your office visit. This may include amounts for co-pays, services, orders of glasses and/or contact lenses, and past-due balances.

Billing Information: Please provide your complete and accurate information (address, phone number, insurance), and notify us of changes to any of your information. We will use reasonable efforts to submit claims to your payer and provide you with statements. Charges that are not covered by insurance, including deductibles, will remain your responsibility. If for any reason amounts that you owe are not paid promptly, including statements returned as undeliverable, your account may be subject to additional finance charge fees.

Finance Charge Fees: For any past due amounts over 30 days Isthmus Eye Care shall be entitled to payment from you with interest at a rate of 1.5% per month (18% per annual). Delinquent accounts will be turned over to an outside collection agency if unpaid after 90 days without further notice. You are responsible for all associated court fees and a one time $30 collection agency fee.

I have thoroughly read and agree to this Financial Policy. I also hereby authorize the release of pertinent medical information to the insurance carrier(s). This consent is in place until revoked in writing.

Patient Name: _____

Signature _____ Date____/____/____

(Parent if under the age of 18)

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