



Vicki S. Borowicz, OD
Jason G. Jedlicka, OD
Kimberly D. Jedlicka, OD

Patient Information:

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ [ ] M [ ] F S.S.#: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Parent/Spouse's Name: \_\_\_\_\_

Other Family Members Living At Home:

Name \_\_\_\_\_ Age \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

How did you hear about Valley Eye Clinic/Who referred you: \_\_\_\_\_

Lifestyle Questions

What do you do at work or school that affects your eyes (e.g. computer work, driving, landscaping)

What are some of your favorite activities (e.g. fishing, watching TV, sewing, sports)

Insurance Information

Primary Insurance Co: \_\_\_\_\_

Policy Holder's Name & Date of Birth: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ S.S.#: \_\_\_\_\_

Secondary Insurance Co: \_\_\_\_\_

Policy Holder's Name and Date of Birth: \_\_\_\_\_

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including diagnosis and the records of my treatment or examination rendered to my child or me during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X \_\_\_\_\_
SIGNATURE OF PATIENT (Or parent if a minor) DATE



223 East First Street #101  
 Jordan, MN 55352  
 Ph: (952) 492-2350 Fax: (952) 492-6162

General Health and Eye History

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_  
 Family Physician: \_\_\_\_\_ Clinic: \_\_\_\_\_ Tel#: \_\_\_\_\_

**Medical History:** Do you have or have had any of the following problems, please "X".

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Joint - Muscle Pain – Arthritis - Fibro
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (or prior history)
<input type="checkbox"/>	<input type="checkbox"/>	Stroke - Neurologic Disease - MS
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Cholesterol - Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems
<input type="checkbox"/>	<input type="checkbox"/>	Blood or Bleeding Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Asthma - Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Stomach – Acid Reflux - Crohns
<input type="checkbox"/>	<input type="checkbox"/>	Fever – Wgt Loss – Dizziness - Nausea

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Ears - Mouth - Nose – Throat
<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease – Rosacea - Dermatitis
<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Disease
<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Problems – Anxiety - Depression
<input type="checkbox"/>	<input type="checkbox"/>	Kidney - Urinary - Genital Disease - Hysterectomy
<input type="checkbox"/>	<input type="checkbox"/>	HIV – AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Reaction to Anesthetics
<input type="checkbox"/>	<input type="checkbox"/>	Currently Pregnant - Breast Feeding
<input type="checkbox"/>	<input type="checkbox"/>	Smoker
<input type="checkbox"/>	<input type="checkbox"/>	Other:

Past Surgeries/Innesses/Chemo: \_\_\_\_\_

Medications you are taking: \_\_\_\_\_

Allergies: \_\_\_\_\_

**Family History:** Do you or anyone in your immediate family (siblings/parents/maternal & paternal grandparents) have or have had any of the following problems, please "X".

SELF	FAMILY	
<input type="checkbox"/>	<input type="checkbox"/>	Cataract
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Detached retina
<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration
<input type="checkbox"/>	<input type="checkbox"/>	Contact Lenses
<input type="checkbox"/>	<input type="checkbox"/>	Crossed Eyes

SELF	FAMILY	
<input type="checkbox"/>	<input type="checkbox"/>	Colorblindness
<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye
<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems - Hypertension
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid

Last Eye Exam: \_\_\_\_\_

Prior surgery, laser surgery, or injury to eyes (month & year): \_\_\_\_\_

Recent Social History (please check all that apply):  
 Job Change                       Death in Family                       Recent Diagnosis of Family Member  
 Recent Travel                       None

Are you interested in (please check all that apply):  
 Contact Lenses                       Orthokeratology/CRT                       Laser Vision Correction

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**RELEASE OF INFORMATION**

**Privacy / Confidentiality of Patient Records**

With the exception of any information necessary to file your insurance, do you wish to have Valley Eye Clinic release any eye examination information without your written or stated permission?

\_\_\_ Yes, release the information in my records

\_\_\_ No, please keep the information confidential and do NOT release it without my written or stated permission.

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**ASSIGNMENT OF BENEFITS**

The Patient/Guarantor assigns all the insurance benefits and/or Medicare benefits directly to Valley Eye Clinic. The Patient/Guarantor authorizes the release of all necessary information to file and complete the insurance claim(s).

**FINANCIAL POLICY**

- I understand that I am responsible for payment of services rendered and any materials provided, including any co-payment and deductibles not covered by my insurance.
- OTHER CHARGES: Balances older than 30 days may be subject to additional collection fees, service charge fees, late fees, and/or interest charges of 2% per month; an annual percentage rate of **24%**. Returned checks will carry an additional **\$25 charge** to the patient's account balance. Should our office find it necessary to place your account with an attorney for collection, all charges incurred in this process will be your responsibility.
- Referrals/Disputes: If a referral from your primary care clinic is required, and you choose to be seen without the necessary referral, you agree to be responsible for the charges incurred if your insurance company refuses to pay for your visit with us.
- If for any reason you dispute the payments made by your insurance company, it is your responsibility to contact the insurance company.

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Signing this document signifies that you have been offered a copy of our Notice of Privacy Practices.

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct healthcare operations involving our office. The Notice of Privacy Practices we have available describes these uses and disclosures in detail.

By signing below, I authorize Valley Eye Clinic & Optical to contact me via postcard, letter, phone/voicemail. or e-mail regarding future appointments, eyewear orders, product offerings, or treatment information.

I acknowledge that I have reviewed the Notice of Privacy Practices from Valley Eye Clinic

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\_\_\_\_\_  
Patient's Signature (Guarantor/Guardian, if patient is a minor)

\_\_\_\_\_  
Front Desk Initials