



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: _____ Primary Care Clinic: _____ Tel #: (____) _____
Last Eye Exam: _____ Smoker: [] Yes [] No Allergies to Medications: _____
Medications you are currently taking: _____
Past Surgeries, Chemo, or Eye Injuries: _____

Medical History: Please circle any of the following that currently apply to you. If nothing applies to you, then please circle "NONE":

- Allergy - Dairy, Dust, Molds, Penicillin, Pollens, Seasonal Allergies, Reaction to Anesthetics, Other: _____ NONE
Cardiovascular - High Blood Pressure/Hypertension, Heart Murmur, Heart Problems, Stroke, Other: _____ NONE
Constitutional - Appetite Gain, Appetite Loss, Anemia, Blackouts, Constipation, Cramps, Dizziness, Fainting, Fatigue, Fever, Nausea, Night Sweats, Nosebleeds, Weakness, Weight Gain, Weight Loss, Other: _____ NONE
Endocrine - Crohns, Cholesterol, Diabetes, Thyroid Disease, Other: _____ NONE
Gastrointestinal - Cancer (Colon, Liver, Lung), Acid Reflux, Other: _____ NONE
Genitourinary - Cancer (Prostate, Uterine), Genital Disease, Hysterectomy, Kidney Problems, Urinary Problems, Other: _____ NONE
Head - Sinusitis, Ear Infection, Chronic Cough, Hearing Loss, Headaches, Other: _____ NONE
Hematologic/Lymphatic - Anemia, Blood or Bleeding Disorder, Cancer (Breast, Lymphatic), Coagulation Disorder, Leukemia, Muscle Cramps, Other: _____ NONE
Immunologic - Aids, HIV, Other: _____ NONE
Integumentary - Acne, Dermatitis, Eczema, Lupus, Photosensitivity, Warts, Other: _____ NONE
Musculoskeletal - Arthritis, Down's Syndrome, Fibromyalgia, Joint or Muscle Pain, Muscular Dystrophy, Osteoporosis, Scoliosis, Other: _____ NONE
Neurological - Bell's Palsy, Brain Tumor, Cerebral Palsy, Dyslexia, Epilepsy, Headache, Muscular Dystrophy, Multiple Sclerosis, Parkinson's Disease, Vertigo, Other: _____ NONE
Psychiatric - ADD, Alcoholism, Alzheimer's, Anxiety Disorder, Autism, Bi-Polar Disorder, Dementia, Depression, Insomnia, Learning Disability, Schizophrenia, Other: _____ NONE
Respiratory - Asthma, Bronchitis, Cystic Fibrosis, Emphysema, Smoker, Other: _____ NONE

Family History: please list any immediate family members (ie. father, mother, sister, brother) that have any of the following:

Cataract: _____ Glaucoma: _____ Detached Retina: _____
Macular Degeneration: _____ Crossed Eyes: _____ Colorblindness: _____
Lazy Eye: _____ Cancer: _____ Diabetes: _____
Heart Problems: _____ Hypertension: _____ Thyroid: _____

NO ONE IN MY FAMILY HAS or HAS HAD ANY OF THE ABOVE CONDITIONS _____
Patient's Initials

Social History: Please circle any of the following that currently apply to you:

- Job Change Death in the family Recent Diagnosis of Family Member
Recent Travel None

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.

_____ intit.

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.

_____ intit.

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

_____ intit.

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

Front Desk Initials