Name			Date of Birth	Gender	Marital Status
PATIENT First: _____	MI ___	Last _____	___/___/___	___	_____

The following information regards the person responsible for any bills or notification from this office,

that person's name is _____.

Address: _____
(Home): Street City State Zip Code

(Work): _____
Name Street City State Zip Code

Phone: Cell ( ) _____ Home ( ) _____ Work/Other ( ) _____

Social Security #: _____ Driver's License #: _____

PRIMARY INSURANCE INFORMATION: ☐ HMO ☐ PPO ☐ Indemnity ☐ Medicare ☐ Other

Company _____ Address _____

Insured's Name: First _____ MI ___ Last _____

Group #: _____ Plan #: _____ HMO/PPO Member #: _____

Employer _____ Address _____

Insured: Date of Birth ___/___/___

SECONDARY INSURANCE INFORMATON: ☐ HMO ☐ PPO ☐ Indemnity ☐ Medicare ☐ Other

Company _____ Address _____

Insured's Name: First _____ MI ___ Last _____

Group #: _____ Plan #: _____ HMO/PPO Member #: _____

Employer _____ Address _____

Insured: Date of Birth ___/___/___

List any member of your family that has previously seen Dr. Busse _____

Who referred you and/or you to Dr. Busse? _____

OFFICE POLICY AND PAYMENT AGREEMENT

All office visits are to be paid for at the time of your visit unless prior arrangements have been made. We do not file insurance on office visits unless we have a contract with your insurance company. We can, however, provide you with paperwork to submit an insurance claim yourself. Please feel free to discuss any of the charges or policies with our staff. We are glad to work with you in anyway we can. It is your responsibility now and in the future to notify our office of any changes in your insurance company.

Date: _____, I, _____, hereby agree to be financially responsible for fees incurred. Authorize the release of any medical information necessary to process the claim and request payment of insurance benefits, including Medicaid and other government sponsored programs to Dr. Megyn L. Busse M.D. I hereby grant authority to Dr. Megyn L. Busse M.D. or any other provider employed by this practice, to perform an eye examination including tests necessary in the diagnosis and treatment of this patient.

Signature: _____ Date: _____

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Birth Date _____

Name of physician referring you _____ Physician Phone _____

Physician Address _____ Date of last eye exam _____

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas? If "yes", provide information.

	YES	NO	EXPLANATION OF PROBLEM
Integument (skin)	☐	☐	
Head	☐	☐	
Headaches	☐	☐	
Migraines	☐	☐	
Eyes	☐	☐	
Loss of vision	☐	☐	
Double vision	☐	☐	
Dryness	☐	☐	
Mucous discharge	☐	☐	
Redness	☐	☐	
Sandy or gritty feeling	☐	☐	
Itching	☐	☐	
Burning	☐	☐	
Excess tearing/watering	☐	☐	
Occasional tearing	☐	☐	
Glare/Light sensitivity	☐	☐	
Eye pain or soreness	☐	☐	
Ears, nose, mouth, throat	☐	☐	
Hay fever	☐	☐	
Sinus congestion	☐	☐	
Runny nose	☐	☐	
Post-nasal drip	☐	☐	
Chronic cough	☐	☐	
Neck	☐	☐	
Respiratory (lungs/breathing)	☐	☐	
Chronic bronchitis	☐	☐	
Cardiovascular (head/blood vessels)	☐	☐	
Gastrointestinal (stomach/intestines)	☐	☐	
Genitourinary (genitals/kidney/bladder)	☐	☐	

	YES	NO	EXPLANATION OF PROBLEM

Bones, joints, muscles	☐	☐	
Muscle pain	☐	☐	
Joint pain	☐	☐	
Neurologic system	☐	☐	
Lymphatics (lymph nodes/swelling)	☐	☐	
Hematopoietic (blood)	☐	☐	
Allergic/Immunologic	☐	☐	
Head allergy symptoms	☐	☐	
Seasonal allergies	☐	☐	
Hay fever symptoms	☐	☐	
Psychiatric	☐	☐	

PAST HISTORY

List any medications you take _____

Do you have allergies to any medication? ☐ YES ☐ NO

If YES, list medications _____

List all major illnesses and injuries _____

List any surgeries you have had in the past _____

List all hospitalizations with explanations of what they were for _____

Have you had crossed eyes, lazy eye, drooping eyelid, prominent eyes, previous contact lens wearer?

Have you ever had sexual contact with a person who may have been exposed to or infected with the AIDS virus?

☐ YES ☐ NO

Have you ever had any of the following sexually transmitted diseases:

Gonorrhea ☐ YES ☐ NO

Syphilis ☐ YES ☐ NO

FAMILY HISTORY

What is the health status or cause of death of your parents, siblings or children?

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness	☐	☐	_____
Cataract	☐	☐	_____
Glaucoma	☐	☐	_____
Macular degeneration	☐	☐	_____
Retinal detachment	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart attacks	☐	☐	_____
High blood pressure	☐	☐	_____
Kidney disease	☐	☐	_____
Stroke	☐	☐	_____

SOCIAL HISTORY

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Current Occupation _____

Do you currently wear glasses? ☐ YES ☐ NO

If YES, how long have you had them? _____

Do you currently wear contact lenses? ☐ YES ☐ NO

If YES, how long? _____

Are they comfortable? ☐ YES ☐ NO

If NO, have you ever tried to wear contacts before? ☐ YES ☐ NO

Do you use street drugs? ☐ YES ☐ NO

If YES, please indicate what? _____

Do you drink alcohol? ☐ YES ☐ NO

If YES, how many glasses a day? _____

Do you smoke? ☐ YES ☐ NO

If YES, how many packs a day? _____

Education level (Please check):

☐High school graduate ☐College graduate ☐Post-graduate degree ☐Other

History Reviewed.

Physician's signature: _____ Date: _____

Austin Pediatric Ophthalmology & Strabismus

Important Patient Information

Refraction Policy: 92015

What is a refraction exam?
This test is a determination of an eye's refractive error and the best corrective lenses to be prescribed. Doctors agree that this test is a necessary element of most visits, and it is used to create prescriptions for glasses and/or contact lenses, and/or to evaluate possible changes In vision due to medical conditions. This is essential in order to determine if a decrease in vision is due to only a need for glasses, which is easy to correct, or if another medical reason might be keeping the eye from seeing.

Sensorimotor Examination: 92060

What is a sensory motor exam?
A sensory motor examination detects, assesses, monitors, and/or manages strabismic conditions. This is an expanded examination which requires additional time, effort, and expertise in measurement of the ocular deviation in various fields of gaze, different distances, and/or with and without optical correction. Doctors agree that information from the sensorimotor examination is used to plan medical, optical, and surgical treatments for these conditions and can have important visual, developmental, and/or systemic implications.

Does my insurance plan pay for this test/exam?

Your insurance may consider these procedures excluded from your benefits and/or a non-covered benefit.

What do you charge for these exams?

In the event that your insurance does not cover the **92015** or **92060** the cost to you will be **$50.00 per test/exam performed.**

I have read and understand the above, and I have had the opportunity to ask questions

_____
Patient Name

_____ _____
I agree to have the following test/exam performed Date

_____
I decline for the following test/exam to be performed
and decline a glasses and/or contact prescription

Austin Pediatric Ophthalmology & Strabismus

Patient Financial Responsibility Agreement

As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. Not all services are covered in all insurance contracts. In addition, you should be sure that your physician is listed as a participating provider by your insurance company. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges.

In the event that your insurance is not valid or your coverage was terminated at the time the services are rendered, you will be solely responsible for the full amount of your office visit and/or any procedures rendered.

In addition, if your insurance plan determines a service or product to be "not covered,"you will be responsible for the complete charge of such services.

I agree to be responsible for the payment of ALL unpaid services rendered on my behalf or my dependents.

_____ _____

Patient/Guardian Signature Date

Austin Pediatric Ophthalmology & Strabismus

At Austin Pediatric Ophthalmology we are required to implement the Meaningful Use Initiatives. As a result, we are collecting the government-mandated information below. The purpose of Meaningful Use is to ultimately improve patient care and lower health care costs.

The information you provide will be used for reporting purposes only.

Today's Date _____

Patient Name _____ Patient DOB _____

Parent Email _____

Race

□African American

□Asian

□Caucasian

□Hispanic

□Other

□ Refuse to report

Ethnicity

□Hispanic

□Not Hispanic

□Refuse to Report

Primary Language

□ English

□Spanish

□Other

Preferred Pharmacy

Pharmacy Name _____

Pharmacy Address _____

Parent Signature _____