

DATE: _____

Dear _____

Welcome to our practice. We are delighted to be part of your health care team. Our records indicate that you have an eye appointment scheduled with

- Steven Unterman, M.D.**
- Joseph Parelman, M.D.**
- Annette Manion, O.D.**

on _____ at our _____ location.

We have enclosed a health questionnaire and a map to our office. Please complete the health questionnaire and bring it with you to your appointment.

It is very important to bring all of the following information with you as well.

- 1. Your insurance card and referral if required by your insurance plan.
(Please call your primary care physician if a referral is needed
PRIOR to your appointment with us.)**
- 2. A list of all the medications you are currently taking**
- 3. Payment for any applicable co-pay, co-insurance and/or
refraction charge**

**If you need to make payment arrangements, please call our
Business Office at 913 384-3087.**

If you have questions at any time, please feel free to call us. We look forward to seeing you soon.

Sincerely,

The Staff and Physicians of Mid-America Eye Center

www.midamericaeye.com

3830 West 75th Street
Prairie Village, KS 66208

(913) 384-1441

111 N. Main Street
Nevada, MO 64772

(417) 667-8722

204 West Chestnut
Butler, MO 64730

(660) 679-6478

FAX
(913) 384-3437
TOLL FREE
1-800-628-4258

MID-AMERICA EYE CENTER, PA
Patient Information Sheet

Date:	Acct.#:	How were you referred to our office?:			
Patient Name:					Sex: Male Female
Mailing Address:		City:	State:	Zip:	
Home Phone:		Birthdate:	Social Security Number:		
Parents (if patient is a minor):					
Is Child Covered Under Parents Insurance:			Is There Any Secondary Insurance:		

EMPLOYER INFORMATION

Employer:			Employer Phone:		
Employer Address:		City:	State:	Zip:	

RESPONSIBLE PARTY

Name:		Mailing Address:			
Social Security Number:		Birthdate:	Employer:		
Employer Address:				Phone:	
*In Case of Emergency Contact:				Phone:	

Primary Care Physician _____

Is this Injury a Result of: Work Related _____
 Motor Vehicle Accident _____
 Accident (Other) _____

Primary Insurance Company:			Secondary Insurance Company:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone:			Phone:		
Policyholder:	Date of Birth:		Policyholder:	Date of Birth:	
Policy #:			Policy #:		
ID #:	Social Security Number:		ID #:	Social Security Number:	

I hereby authorize Mid-America Eye Center as a holder of medical information, to release to my insurance carrier or its intermediaries any information needed for this or future related claim(s). I further request payment be made to Mid-America Eye Center and authorize them to submit claims on my behalf for any bills or services furnished to me during the next 12-month period (year). I hereby acknowledge and understand that I am financially responsible for any portion of my bill not covered by my insurance carrier. If this account is placed in the hands of a collector or an attorney for collection, reasonable cost of collection including attorneys fees will be paid by the undersigned.

Date _____

Signature _____



Joseph J. Parelman, M.D.
 Steven R. Unterman, M.D.
 Annette S. Manion, O.D.
 913 384-1441
 800 628-4258

Medical History Questionnaire

Name: _____

Date: _____ Age: _____ Date of Birth: _____

Do you presently have any problems in the following areas? If "yes," please give an explanation:

<u>EYES</u>	Yes	No	Explanation of Problem
Loss of Vision	___	___	_____
Blurred Vision	___	___	_____
Distorted Vision (Halos)	___	___	_____
Loss of Side Vision	___	___	_____
Double Vision	___	___	_____
Dryness	___	___	_____
Mucous Discharge	___	___	_____
Redness	___	___	_____
Sandy or Gritty Feeling	___	___	_____
Itching	___	___	_____
Burning	___	___	_____
Foreign Body Sensation	___	___	_____
Excess Tearing/Watering	___	___	_____
Occasional Tearing	___	___	_____
Eye Pain or Soreness	___	___	_____
Chronic Infection of Lids	___	___	_____
Sties, Chalazion	___	___	_____
Fluctuating Vision	___	___	_____

Ears, Nose, Mouth, Throat

Sinus Congestion	___	___	_____
Dry Throat/Mouth	___	___	_____

please continue to the following page

	Yes	No	Explanation of Problem
<u>Cancer</u>	—	—	_____
<u>Cardiovascular</u>	—	—	_____
Heart	—	—	_____
High Blood Pressure	—	—	_____
<u>Respiratory</u>	—	—	_____
Lungs/Breathing	—	—	_____
<u>Gastrointestinal</u>	—	—	_____
Stomach/Intestines	—	—	_____
<u>Genitourinary</u>	—	—	_____
Kidney/Bladder	—	—	_____
<u>Musculoskeletal</u>	—	—	_____
Muscle or Joint Pain	—	—	_____
<u>Neurological</u>	—	—	_____
<u>Psychiatric</u>	—	—	_____
<u>Endocrine - Diabetes</u>	—	—	_____
<u>Allergic</u>	—	—	_____
Seasonal Allergies	—	—	_____
Hay Fever Symptoms	—	—	_____

List all major illnesses and injuries you have had in the past: _____

List any surgeries you have had in the past: _____

<u>Family History</u>	Yes	No	Relationship to You
Blindness	—	—	_____
Cataract	—	—	_____
Glaucoma	—	—	_____
Macular Degeneration	—	—	_____
Retinal Detachment	—	—	_____
Diabetes	—	—	_____
Heart Problems	—	—	_____
Cancer	—	—	_____

Social History

Current Occupation: _____

Do you drive?	Yes ___	No ___
Do you have visual difficulty when driving?	Yes ___	No ___
Do you have a problem with night vision?	Yes ___	No ___
Have you ever tried to wear contacts?	Yes ___	No ___
Do you currently wear glasses?	Yes ___	No ___

If "yes," how long have you had the current pair? _____

Do you smoke? Yes ___ No ___ If "yes," how many packs a day? _____

Have you ever had a blood transfusion? Yes ___ No ___

Do you drink alcohol? Yes ___ No ___ If yes, how many glasses per day? _____

What are your hobbies or special interests? _____

To Be Completed by Physician and Staff

Medications and Dosages

Allergies

HX Reviewed: _____ No Changes: _____ Additions as Noted: _____

Doctor's Signature: _____ Date: _____

REFRACTIONS

You may see a charge for 92015 Refraction on your statement and may wonder why this was charged separately from your eye examination or office visit charge.

Q. What is a refraction?

A. A refraction is a test to determine whether you would benefit from spectacles . Your refractive error may not be great enough for you to require a spectacle prescription, but this cannot be determined without performing the refraction. If you have a medical problem, a refraction may be performed to see how the problem has affected your vision.

Q. Are there different levels of refractions?

A. There are 3 different levels of refractions depending on how complicated the refraction is.

The lowest level is usually a quick check. Often times the patient is not given a spectacle prescription.

A mid level refraction is the most common and is the one usually performed during a routine eye examination.

The higher level refraction is sometimes necessary after certain surgical procedures and with certain eye diseases. It is typically more complicated and takes longer to perform.

Q. Will my insurance pay for a refraction?

A. Most insurances will not pay for refractions. If you have vision coverage a refraction is almost always covered, although it may not apply during a medical eye exam.

Medicare considers a refraction part of routine care making it a non-covered charge. Medicare will not pay for a refraction for any reason and considers this portion of an eye examination the patient's responsibility.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

Notice to Patient:

Mid-America Eye Center is required to provide you a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment if you wish.



I acknowledge that I have received a copy of Mid-America Eye Center's Notice of Privacy Practices.

Please print your name here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient, but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency it was not possible to obtain an acknowledgment.
- We weren't able to communicate with the patient.
- Other (Please provide specific details)

Employee signature

Date