Grand Ledge Optometry, P.C.
11973 Sweetwater Dr, Ste B
Grand Ledge, MI 48837
517-622-2020

Welcome to GRAND LEDGE OPTOMETRY! Please complete the front and back of the *Medical History Questionnaire* as completely as possible, including all medications with their dosage and frequency. Also, we ask that you read and sign our *Statement of Practice Policies, Acknowledgement of Receipt- Notice of Privacy Practices, and Insurance Claim Authorization.* Please bring these forms filled out to your appointment. A copy of our Privacy Practices is posted online or available to you at our office.

MASKS ARE REQUIRED AT THIS TIME TO ENTER OUR OFFICE

Please arrive 10-15 minutes early for your first appointment.

Please bring the following items with you the day of your appointment:

- Completed Medical History Questionnaire
- Signed Statement of Practice Policies
- Signed receipt of Privacy Practices and Insurance Claim Form Authorization
- Photo ID
- Vision and medical insurance cards
- Complete list of current medications with dosage and frequency including over the counter medications, if applicable.
- Copay (if required by your insurance company)
- Any glasses, prescription sunglasses or contact lenses that you are currently wearing
- Name, address and phone number of your primary care physican

Payment is due at the time services are rendered. We participate with many major insurance plans. For these plans, copayments, deductibles and coinsurance will be collected at the time of service if amount is known. Payment in full is requested at the time of the visit for patients on insurance plans with which we do not participate, or patients who are self pay. We accept cash, check, American Express, Discover, MasterCard, Visa and Care Credit.

Dilation of the eyes is routinely performed on patients at our office. This process involves instilling drops into the eyes to make the pupil (black opening of eye) larger so that the doctor can perform a more comprehensive health evaluation of your eyes. There is no additional charge for this service. Blurred near vision and light sensitivity are short-term side effects that normally last 2-4 hours. We recommend having sunglasses with you as well as a driver if you have not had this procedure performed in the past.

We look forward to serving your vision needs! Please do not hesitate to call the office at (517) 622-2020 if you have any questions regarding your appointment.

Sincerely,
Dr. Andrew Schmitzer and Staff at GRAND LEDGE OPTOMETRY

Medical History Questionnaire

First Name:______________________________ Middle Initial:_____ Last Name:______________________________ Today's Date: __________________

Male/Female (circle per birth certificate) Preferred pronoun identified by: He/Him She/Her Them/They Other___________________

Mailing Address:____ Home Phone:____________________________ Cell:________________________

City:______________________________ State:________Zip: _______________ Work Phone: _______________________ Prefer: Phone, Text, or Email

Birth Date:_______/_______/_________ Occupation:__________________________________ Email: ____

Social Security # _________-_______-___________ Last Vision Exam: ________/_______/________ Last Medical Exam: _______/_______/_________

Name of Medical Doctor:______________________________________ Guardian (if applicable): ____

Vision Insurance:____ Medical Insurance:____

Cardholder Information: Name___________________________________ Social Security #________-______-___________ DOB______/______/________

Referred to our office by: ____

MEDICAL HISTORY

Do you have any allergies to medications? ____ yes ____ no If yes, please list names and reaction if known

____

List any medications you take (including oral contraceptives, aspirin, over-the-counter medications, and home remedies)

____

____

List all major injuries, surgeries, and/or hospitalizations you have had

____

Currently pregnant? ____ yes ____ no

Currently nursing? ____ yes ____ no

EYE HISTORY

List any eye conditions you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infection or injury

____

Do you wear glasses? ____ yes ____ no

Are you thinking of new glasses today? ____ yes ____ no

Do you wear contact lenses? ____ yes ____ no

Are you thinking of new contact lenses today? ____ yes ____ no

Type of contact lenses:
Check all that apply ____rigid (gas permeable) ____soft ____extended wear (sleep in them) ____toric ____multifocal

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children—living or deceased) for the following conditions:

	YES	NO	Relationship
Blindness	____	____	____
Cataract	____	____	____
Glaucoma	____	____	____
Macular Degeneration	____	____	____
Retinal Detach or disease	____	____	____
Lazy Eye/Strabismus	____	____	____
Diabetes	____	____	____
High Blood Pressure	____	____	____
Cancer	____	____	____
Lupus	____	____	____
Thyroid disease	____	____	____
Other ____________________	____	____	____

--------------------PLEASE TURN FORM OVER AND FILL OUT THE OTHER SIDE--------------------

SOCIAL HISTORY

This information is kept strictly confidential and is required for insurance purposes.

Do you drive? ____ yes ____ no If yes, do you have difficulty when driving? ____ yes ____ no If yes, please describe:

____

Do you currently or is there any history of tobacco product use? ____ yes ____ no Type/amount/how long? ____________________________

Do you drink alcohol? ____ yes ____ no Type/amount/how long? ______________________________

Do you use illegal drugs? ____ yes ____ no Type/amount/how long? ______________________________

Have you ever been exposed to or infected with ____ Gonorrhea ____ Hepatitis ____ HIV ____ Syphilis

REVIEW OF SYSTEMS

Do you currently or have you had problems in the following areas:

Eyes
- Blindness ____ yes ____ no
- Blurred Vision ____ yes ____ no
- Burning ____ yes ____ no
- Chronic Eye Infection ____ yes ____ no
- Distorted Vision ____ yes ____ no
- Double Vision ____ yes ____ no
- Dryness ____ yes ____ no
- Eye Injury ____ yes ____ no
- Eye Pain or Soreness ____ yes ____ no
- Flashes ____ yes ____ no
- Floaters ____ yes ____ no
- Foreign Body Sensation ____ yes ____ no
- Glare/Light Sensitivity ____ yes ____ no
- Halos ____ yes ____ no
- Itching ____ yes ____ no
- Loss of Side Vision ____ yes ____ no
- Mucous Discharge ____ yes ____ no
- Red eyes ____ yes ____ no
- Sandy/Gritty Feeling ____ yes ____ no
- Tired Eyes ____ yes ____ no
- Watery Eyes ____ yes ____ no

Allergic/Immunologic
- Hay Fever ____ yes ____ no
- Medicine Allergies ____ yes ____ no

Constitutional
- Fever ____ yes ____ no
- Weight Loss ____ yes ____ no
- Weight Gain ____ yes ____ no

Cardiovascular/Vascular
- Heart Pain ____ yes ____ no
- High Blood Pressure ____ yes ____ no
- Vascular Disease ____ yes ____ no

Ears, Nose, Mouth, Throat
- Allergies/Hay Fever ____ yes ____ no
- Sinus Congestion ____ yes ____ no
- Chronic Cough ____ yes ____ no
- Dry Throat/Mouth ____ yes ____ no

Endocrine
- Diabetes ____ yes ____ no
- Thyroid Problems ____ yes ____ no
- Other Glands ____ yes ____ no

Gastrointestinal
- Diarrhea ____ yes ____ no
- Constipation ____ yes ____ no
- Ulcers ____ yes ____ no

Genitourinary
- Genitals ____ yes ____ no
- Kidney Problems ____ yes ____ no
- Bladder Problems ____ yes ____ no

Hematologic/Lymphatic
- Anemia ____ yes ____ no
- Bleeding Problems ____ yes ____ no

Integumentary
- Dry Skin ____ yes ____ no
- Other Skin Conditions ____ yes ____ no

Musculoskeletal
- Rheumatoid Arthritis ____ yes ____ no
- Muscle Pain ____ yes ____ no
- Joint Pain ____ yes ____ no

Neurological
- Headaches ____ yes ____ no
- Migraines ____ yes ____ no
- Seizures ____ yes ____ no

Psychiatric
- Nervous Disorders ____ yes ____ no
- Depression ____ yes ____ no
- Compulsive Behavior ____ yes ____ no

Respiratory
- Asthma ____ yes ____ no
- Shortness of Breath ____ yes ____ no
- Emphysema ____ yes ____ no

Please explain if you answered YES to any condition above that needs more detail or if a condition was not listed:

____

____

GRAND LEDGE OPTOMETRY

11973 Sweetwater Drive, Suite B
Grand Ledge, MI 48837
Phone: (517) 622-2020 Fax: (517) 627-4397
www.gloptometry.com

STATEMENT OF PRACTICE POLICIES

- PAYMENT IS DUE AT THE TIME OF SERVICE

All professional fees are due on the day of service. Office credit or payment plans will not be offered unless given approval prior to your appointment. This applies to all deductibles, copayments, and other collectable fees.

- BILLING YOUR INSURANCE

Please help us ensure billing accuracy and efficiency by informing us at sign-in of **ANY** changes to your insurance information. Any insurance discrepancies that result in non-payment will be billed to the patient. This includes instances in which there are deductible or copayment amounts, lapses in coverage, the patient provides inaccurate or outdated insurance information, or the patient requires or requests non-covered services. If your insurance company does not pay your claim within 90 days of service, the balance will be automatically billed to you. Statements regarding any patient balances are mailed monthly. If you have any questions regarding a balance, please call our office immediately. Failure to pay the amount due before the next billing statement could result in additional finance fees.

Vision insurance **provides coverage only for wellness examinations and material benefits or discounts for contact lenses or eyeglasses. Your** ***medical insurance*** **provides coverage and will be billed for all visits related to health conditions affecting the eyes, including diabetic evaluations, cataracts, glaucoma, amblyopia (lazy eye), infections, dry eyes, allergies, or any other instance where the reason for examination is not for routine services.** We are happy to provide information regarding your insurance coverage, however, the patient is ultimately responsible for understanding their insurance benefits/coverage, deductibles, and copays.

- ORDERING OF GLASSES AND CONTACT LENSES

We require a minimum **50%** down payment on all orders before they will be manufactured**. Payment in full is required before glasses or contact lenses will be dispensed.** If your order is not picked up within 90 days from the date of order, the down payment will be forfeited and applied to our cost of replacement or return of product.

- RETURNS / EXCHANGES

All of our glasses and contact lenses are custom-made or ordered for each individual patient, therefore, all purchases are non-refundable. No cancellations can be accepted once a lab has started making patient eyewear. Exchanges may be made within the first 30 days after purchase on a limited basis. There may be a fee for exchanges, which will be discussed on a case-by-case basis. If you are dissatisfied with your prescription, please notify us immediately. Your happiness is extremely important to us, and we will act quickly to help resolve any issues you may be having. If you first notify our office of trouble with your prescription (adaptation, blurry vision, etc.) more than 30 days after you received your glasses or contact lenses, there may be a fee for prescription checks or modifications and remakes. If there has been an error on our part, we will work to quickly resolve the problem at no cost to you.

- REFUNDS

If there is a need for a refund (i.e. patient accidentally charged incorrectly or insurance overpayment), we reserve the right to issue refunds via check, even if the purchase was made in cash. Checks will be sent by mail, and you should receive the funds within 1-2 weeks. Credit cards can only be refunded to the same account used for the purchase. If a patient paid via personal check, the check must have cleared before we will issue any refunds. **There will be NO REFUND of professional fees (contact lens fitting fees, examination fees, etc.) if services have already been performed.**

By signing below, I am confirming that I have read the above office policies. I understand that if I have any questions or concerns regarding these policies, that I am responsible for contacting a staff member for clarification before services are rendered.

_______________________________ Signature of Patient, Parent, Guardian, or Personal Representative

__________ Date

_______________________________ Please PRINT the name of the Patient, Parent, or Guardian

Grand Ledge Optometry

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I received a copy of GRAND LEDGE OPTOMETRY'S Notice of Privacy Practices.

Patient Name ____

Signature ____________________________ Date ___________

Insurance Claim Form Authorization

I hereby authorize GRAND LEDGE OPTOMETRY to release pertinent information about me to file a claim with my insurance company and assign benefits to be paid to GRAND LEDGE OPTOMETRY as indicated on CMS-1500 claim line #12 and #13. I understand I am financially liable for any balance not covered by my insurance or amount that is to be applied toward my annual insurance deductible. A copy of this signature is valid as an original.

Signature:_________________________________ Date:___________