Todd W. Wild, O.D.
Doctor of Optometry
415 E. Ann St.~P.O. Box 350
Weyauwega, WI 54983
(920)867-3131 www.drtoddwild.com

PATIENT MEDICAL HISTORY FORM

NAME: _____ DATE OF BIRTH: _____ TODAY'S DATE: _____

SEX: Male ☐ Female ☐

Name/location of previous eye care provider: _____

Name/location of Primary Care Doctor: _____

Main reason for your visit today: _____

How did you hear of our office? _____

Do you currently wear glasses or contact lenses? _____

Are you experiencing any of the following visual problems while wearing your glasses or contact lenses:

	YES	NO
Difficulty reading small print	☐	☐
Difficulty with distance vision	☐	☐
Bothered by glare/halos	☐	☐
Eye fatigue with computer work or digital device use	☐	☐

	YES	NO
Do you have burning, gritty or watery eyes?	☐	☐
Do you have long hours of screen time?	☐	☐

Some eye problems can be related to other medical conditions.
Please complete the following Review of Systems:

	YES	NO
EYES		
Blurred vision	☐	☐
Double vision	☐	☐
Inflammatory disorders	☐	☐
Cataract(s)	☐	☐
Glaucoma	☐	☐
Macular degeneration	☐	☐
Other _____		
ALLERGIC/IMMUNOLOGIC		
Drug allergy *	☐	☐
Environmental allergy	☐	☐
Rheumatoid arthritis	☐	☐
Lupus	☐	☐
Other _____		
GASTROINTESTINAL		
Crohn's disease	☐	☐
Colitis	☐	☐
Ulcer	☐	☐
Digestive	☐	☐
Other _____		
PSYCHIATRIC		
Depression	☐	☐
Panic disorder	☐	☐
Schizophrenia	☐	☐
Other _____		

	YES	NO
ENDOCRINE		
Non-insulin dependent diabetes	☐	☐
Insulin-dependent diabetes	☐	☐
Thyroid dysfunction	☐	☐
Hormonal dysfunction	☐	☐
Other _____		
EARS, NOSE, MOUTH AND THROAT		
Upper respiratory tract infection	☐	☐
Ear ache	☐	☐
Runny nose	☐	☐
Sore throat	☐	☐
Ringing/tinnitis	☐	☐
Other _____		
INTEGUMENTARY (SKIN)		
Eczema	☐	☐
Rosacea	☐	☐
Psoriasis	☐	☐
Other _____		
MUSCULOSKELETAL		
Fibromyalgia	☐	☐
Osteoarthritis	☐	☐
Other _____		

(see next page)

Review of Systems (continued)

	YES	NO
CONSTITUTIONAL		
Developmental disability	☐	☐
Weight loss	☐	☐
Fever	☐	☐
Fatigue	☐	☐
Trauma	☐	☐
Other_____		
NEUROLOGIC		
Multiple sclerosis	☐	☐
Epilepsy	☐	☐
Alzheimer's	☐	☐
Parkinson's	☐	☐
Cerebrovascular/Stroke	☐	☐
Other_____		
HEMATOLOGIC/LYMPHATIC		
Anemia	☐	☐
Large volume blood loss	☐	☐
Leukemia	☐	☐
Other_____		

	YES	NO
CARDIOVASCULAR		
Heart disease	☐	☐
Hypertension (high blood pressure)	☐	☐
Stroke	☐	☐
Vascular disease	☐	☐
Other_____		
GENITOURINARY		
STD, viral herpetic, Chlamydia	☐	☐
Other_____		
RESPIRATORY		
Smoking status:		
☐ smoker ☐ nonsmoker		
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Other_____		

FAMILY HISTORY

Does anyone in your immediate family (blood relatives) have any of the following:

	YES	NO	RELATIONSHIP (IF YES)
Glaucoma	☐	☐	_____
Cataracts	☐	☐	_____
AMD (macular degeneration)	☐	☐	_____
Hypertension	☐	☐	_____
Diabetes	☐	☐	_____

MEDICATIONS

Please list all prescribed and over-the–counter medications you are currently taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

*if drug allergies, please list here:

_____ _____
_____ _____
_____ _____

I have answered these questions to the best of my knowledge.

_____ _____
Patient or guardian's signature Date

ABOUT YOUR INSURANCE

There are two types of health insurance that will help pay for your eye care services and optical products. You may have both types of insurance, and Dr. Wild's office accepts most insurance plans in both categories: 1) Vision plans (such as VSP, EyeMed, VIPA, NVA, Superior Vision and a few others) and 2) Medical (such as Blue Cross, Network, United HealthCare, Medicare, and others).

- Vision plans only cover routine vision wellness exams, along with eyeglasses and contact lenses. Vision plans do not cover medical eye care (the diagnosis, management or treatment of eye health problems).

- Medical insurance must be used for medical eye care.

- If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called Coordination of Benefits to do this properly and to minimize your out-of-pocket expense.

- If some fees are not paid by your insurance we will bill you for them, such as deductibles, co-pays or non-covered services as allowed by the insurance contact.

Please provide your insurance cards to our staff so we can make a copy. We need to have your most current medical insurance cards or Medicare card on file in case we should need it in the future for billing your insurance claims.

I have read and accept these policies.

_____ _____

Patient Signature (If a child/minor, parent signature) **Date**

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FINANCIAL POLICY AND PATIENT SIGNATURE ON FILE

At Dr. Todd Wild's optometric office, your care and a positive outcome are our first priority. We are providing this payment guideline information to assist you in meeting your financial responsibilities linked with your care at our office.

ARRANGING PAYMENT

Payment is expected at the time of service. Your glasses are a special order item because they are made to your individual prescription needs. As a result, they require a deposit of ½ down at time of order, with the balance to be paid at time of dispense. We accept cash, check or credit card.

Minor patients: The adult accompanying a minor and the parents (or guardians) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized. In a situation of divorce, the parent bringing in the dependent child for services will be the parent billed and held responsible for any and all charges incurred. This is regardless of the divorce decree.

REGARDING INSURANCE

We may accept assignment of your insurance benefits. However, most insurance companies do not cover at 100%. We require that your portion of the bill be paid at the time of service. The balance is also your responsibility whether your insurance pays or denies. If you are unable to clear your balance within 30 days, a minimum of ⅓ of the balance due is required as monthly payment. **We cannot bill your insurance unless you give us a copy of your current insurance information and authorization.** Your insurance is a contract between you and the insurance company; we are not a party to that contract. If you need a referral for your visit, it is your responsibility to obtain one from your primary care physician prior to our services.

INTEREST AND BILLING CHARGES

We reserve the right to assess a $1.00 billing charge or 1.5% interest (whichever is greater) on balances of 30 days or older. If your account goes into a delinquent state by not having made consistent payments and/or other financial arrangements with our office, you will be notified by mail to call our office and pay on account. If you do not comply within 30 days of that notice, your account may be sent to collections and you will be billed an additional 33.3% of the delinquent balance. This is the percent we are charged by Credit Systems of the Fox Valley to recoup finances on our behalf.

I understand and agree to this financial policy. I hereby authorize payment of medical benefits to Dr. Todd Wild for any services provided to me. I understand that I am responsible for any difference in the amount billed and the amount paid by my insurance. I authorize the release of any medical information necessary to process insurance claims on my behalf. This authorization is in effect immediately.

SIGNATURE_____ DATE_____

(RESPONSIBLE PARTY/GUARDIAN)

PATIENT NAME_____

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Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, state law and federal law.

Dated_____

Authorized to release medical information on this patient's behalf to:

_____

By_____
Patient's Signature

Phone number_____

E-mail _____

E-mail_____

If patient is a minor or under guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

WELCOME TO OUR OFFICE!

PATIENT INFORMATION	
Name:	Birthdate:
Address:	
City:	Zip Code:
Occupation:	
Employer:	
Home Phone:	Work Phone:

INSURANCE INFORMATION	
Primary Insurance Company:	
Insurance ID number:	
Subscriber Name:	Subscriber Birthdate:
Relationship to Subscriber (Please circle one): Self Spouse Dependent Child	
Secondary Insurance Company:	
Insurance ID Number:	

Social Security #:

***Please present any insurance cards and forms to the receptionist

I authorize the release of any medical or other information to process my insurance claims. I also authorize payment of medical benefits to my doctor. It is my understanding that I am responsible to obtain any and all referrals that my insurance company requires for service performed by that doctor. I also understand that I am responsible for any charges not covered by my insurance.

Patient Name (Please print):	
Patient Signature:	Date:

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