ADVANCED EYECARE
• ASSOCIATES •

Kyle D. McMurray, O.D. • Douglas J. Kimball, O.D. • Cynthia K. Johnson, O.D. • Joseph R. Colella, O.D. • Jody L. Fink, O.D.

Thank you for choosing Advanced Eyecare for your vision health. We offer appointment times to fit most lifestyles and strive to provide each of our patients with personal attention and excellent results.

We are excited to announce our new electronic medical record software program. RevolutionEHR is not only the leading cloud-based EHR for optometry, RevolutionEHR is also a complete practice management solution. Features include customizable exam encounters and a care plan library built just for you. This new technology will let our staff schedule appointments, verify your insurance benefits with simple yet flexible data entry.

A requirement to get our new system up and running requires that all of our patients complete the registration process. For your convenience we have enclosed our patient questionnaire to be completed at home.

Please arrive 15 minutes prior to your scheduled appointment time.

Items to bring with you:

- Completed Advanced Eyecare questionnaire
- Vision **and** Medical insurance cards so we can scan them into our new system
- Photo I.D.

Upon arrival we will have you sign our acknowledgment of HIPAA privacy policy.

We ask for your patience as we begin this electronic system. We look forward to meeting with you.

Cordially,
Advanced Eyecare Staff

4265 Fallon Street, Suite 1 • **Bozeman, MT 59718** • Phone: 406-587-0668 • Fax: 406-587-0396 • Toll Free: 1-888-587-0668

91 West Madison, Suite B • **Belgrade, MT 59714** • Phone: 406-388-1988 • Fax: 406-388-2488

Advanced Eyecare.4265 Fallon Street Ste. 1.Bozeman MT 59718
Phone: (406) 587-0668 Fax: (406) 587-0396
Douglas J. Kimball, O.D. Kyle J. McMurray, O.D. Cynthia K. Johnson, O.D. Jennipher R. Harper O.D. Jody L. Fink O.D.

Patient Name: _____

Parent/Guardian: _____

DOB: _____ Male/Female Social Security Number: _____

Address: _____

City: _____ State: _____ Zip _____

Home Phone: _____ Work: _____ Cell: _____

Email: _____

Employer: _____

Pharmacy: _____ Family Physician: _____

Referred By: () Friend () TV Ad () Print Ad () Facebook () Share The Care Program () Other

Race: () Caucasian () Hispanic-Latino () Other: _____
Ethnicity: () Non-Hispanic () Hispanic-Latino

Vision Insurance: _____Policy #: _____

Medical Insurance: _____Policy #: _____

Please sign:
Signature: _____ Date: _____

For Office Use Only:

Check In Scanning: _____Insurance Card (s) _____ABN _____CL Consent

Check Out Scanning: _____Visual Fields _____ Health History _____AE Summary Printed _____Meds list
_____ Frame waiver _____Route slip

OA's: **OPTOMAP DONE Y N** **() New Patient () Established Patient**

Dilated: Y N _____ Previous OPTO patient; Year _____
_____ Previous Revolution patient; Year _____

Exam Co-pay: $_____ _____ Previous Information Entered

DJK KDM CKJ JRH JLF
Circle Visit Type:
Vision Exam Medical Exam Rx Check Contact Lens F-up Contact Lens Fitting Pre/Post-Op Lasik Post-Op Cataract

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Reason For Visit: _____

CHECK THE FOLLOWING CONDITIONS THAT APPLY TO YOU:

	Yes	No
Constitution		
Cancer	☐	☐
Headache	☐	☐
Ear/ Nose/ Throat		
Sinus Condition	☐	☐
Hearing Loss	☐	☐
Dry Mouth	☐	☐
Neurologic		
Migraines	☐	☐
Epilepsy	☐	☐
Tumor	☐	☐
Stroke	☐	☐
Multiple Sclerosis	☐	☐
Cerebral Palsy	☐	☐
Psychologic		
ADD/ ADHD	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Cardiovascular		
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
Respiratory		
Bronchitis	☐	☐
Sleep Apnea	☐	☐
Asthma	☐	☐
Emphysema	☐	☐

	Yes	No
Gastrointestinal (digestive)		
Colitis	☐	☐
Crohn's Disease	☐	☐
Celiac Disease	☐	☐
Musculoskeletal		
Fibromyalgia	☐	☐
Arthritis	☐	☐
Muscular Dystrophy	☐	☐
Gout	☐	☐
Integumentary (skin)		
Rosacea	☐	☐
Shingles (zoster)	☐	☐
Psoriasis	☐	☐
Eczema	☐	☐
Cold sores (simplex)		
Endocrinology		
Type 1 Diabetes	☐	☐
Type 2 Diabetes	☐	☐
Thyroid Condition	☐	☐
Hormone Disorder	☐	☐
Blood Disorders		
Anemia	☐	☐
High Cholesterol	☐	☐
Allergic / Immunologic Conditions		
Lupus	☐	☐
Rheumatoid Arthritis	☐	☐
Sjogren's Syndrome	☐	☐

_____ *Are you currently pregnant or nursing?* YES ☐ NO ☐

Other Medical Conditions or Surgeries: _____

Height: _____ Weight: _____

Do you drink alcohol? YES ☐ NO ☐ Do you smoke? YES ☐ NO ☐ Former Smoker? YES ☐ NO ☐

Do you have (or have you previously had) and of the following eye conditions:

☐ Cataract; ☐ Glaucoma; ☐ Macular Degeneration; ☐ Lazy Eye; ☐ Eye Turn; ☐ Retinal Detachment; ☐ Eye Surgery

Other Conditions or Concerns: _____

Does a member of your family have any of the following conditions?

☐ Cataract; ☐ Glaucoma; ☐ Macular Degeneration; ☐ Lazy Eye; ☐ Eye Turn; ☐ Retinal Detachment; ☐ Eye Surgery

☐ Thyroid Disease; ☐ Diabetes; ☐ High Blood Pressure; ☐ Cancer; ☐ Other: _____

LIST CURRENT MEDICATIONS: _____

_____

_____

LIST CURRENT EYEDROPS: _____

DRUG OR OTHER KNOWN ALLERGIES: _____

LATEX SENSITIVITY? YES ☐ NO ☐

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