ADVANCED EYECARE
• ASSOCIATES •

Kyle D. McMurray, O.D. • Douglas J. Kimball, O.D. • Cynthia K. Johnson, O.D.
Jody L. Fink, O.D. • Jennipher Harper, 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.

Please arrive 10 minutes prior to your scheduled appointment time. This allows us to stay on schedule and update any changes to your electronic medical record.

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

Items to bring with you:

- Completed Advanced Eyecare questionnaire
- Vision **and** Medical insurance cards so we can scan them into our system.
- List of current medications including dosage from your primary medical Doctor
- Glasses, readers or sunglasses with prescription.
- Contact lenses, please bring the box or a pictures of the brand and Rx on the box.

Attention Contact Lens Wearers:

Contact lenses are a medical device and may affect your cornea health. Due to this, in order to renew your contact lens prescription, your eye doctor will perform a contact lens evaluation to check your eye health. This is not part of a routine eye exam and your insurance may consider this a non-covered service.

Payment for services is due at the time of your appointment. We will do our best to verify your medical and/or vision coverage prior to you being seen by a Doctor.

Cordially,
Advanced Eyecare Staff

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

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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