Brian J. Mihok, D.O.
OPHTHALMOLOGY

New Patient Welcome Packet

Comprehensive Medical & Surgical Eye Care

Brian J. Mihok, D.O., Inc.

8940 Kingsridge Drive, Suite 104, Dayton, Ohio 45458
Phone: (937) 433-0454 | Fax: (937) 433-4386

Thank you for choosing Brian J. Mihok, D.O., Inc. for your eye care needs. We are committed to providing you with the highest standard of comprehensive medical and surgical ophthalmology in a caring, professional environment.

Please complete the enclosed forms before your appointment to help us provide efficient, personalized care. If you have any questions, do not hesitate to contact our office.

Your Vision. Our Priority.

PATIENT DEMOGRAPHIC FORM

PERSONAL INFORMATION

Last Name | First Name | Middle

Preferred Name | Date of Birth (MM/DD/YYYY)

Address

City | State | Zip

Home Phone | Cell Phone | Preferred Phone

Email Address

Race | Ethnicity

Sex: M / F | Marital Status | Social Security Number

COMMUNICATION PREFERENCES (circle all that apply)

VOICEMAIL AUTHORIZATION Yes No

TEXT MESSAGE AUTHORIZATION Yes No

EMAIL AUTHORIZATION Yes No

WORK INFORMATION

Employer | Occupation

Work Phone | Work Address

EMERGENCY CONTACT

Name | Relationship | Phone

PHYSICIAN INFORMATION

Primary Care Physician | Phone

Referring Provider | Phone

REFERRAL SOURCE

How did you hear about us? Doctor / Family/Friend / Insurance / Internet / Other: _____

EYE HISTORY

Patient Name: _____ Date: _____

EYE CONDITIONS (circle all that apply)

Cataracts
Diabetic Retinopathy
Fuchs Dystrophy
LASIK/Refractive Surgery
Astigmatism
Glaucoma
Dry Eye Syndrome
Corneal Disease
Previous Eye Surgery
Strabismus (Eye Points Wrong Direction)
Macular Degeneration
Retinal Tear/Detachment
Eye Injury
Amblyopia (Lazy Eye)
Other: _____

CURRENT EYE DROPS (list all)

Drop Name	Which Eye (R/L/Both)	Times/Day

PREVIOUS EYE SURGERIES

Procedure	Which Eye	Year	Surgeon

CURRENT VISION CONCERNS (check all that apply)

Blurry Vision (distance)
Floaters/Flashes
Tearing/Watering
Difficulty Driving at Night
Blurry Vision (near)
Eye Pain/Pressure
Light Sensitivity
Eyelid Drooping
Double Vision
Redness/Irritation
Halos Around Lights
Other: _____

Reason for today's visit:

Do you wear glasses? Yes / No

Contact lenses? Yes / No

Last eye exam: _____

Please note: Our practice does not offer contact lens fittings and cannot fit new patients into contacts.

MEDICAL HISTORY

Patient Name: _____ Date: _____

ALLERGY DETAILS

Any allergies? Yes / No (circle one)

If so, what allergies? _____

_____

OTHER MEDICATIONS (list all current medications)

Medication Name	Dosage (mg)	Times/Day	Reason

PREVIOUS SURGERIES (NON-EYE)

Procedure	Year	Complications?

PHARMACY INFORMATION

Pharmacy Name: _____ Phone: _____

LIFESTYLE

Do you smoke? Yes / No / Quit If yes, how much? _____ Quit date: _____

Do you drink alcohol? Yes / No / Quit If yes, how much? _____ Quit date: _____

Pneumonia Vaccination? Yes / No Flu Vaccine this year? Yes / No

FAMILY HISTORY & REVIEW OF SYMPTOMS

Patient Name: _____ Date: _____

FAMILY HISTORY (circle condition if it applies to you, list relative)

Cancer	Diabetes	Heart Disease
Kidney Disease	Retinal Detachment	Amblyopia (Lazy Eye)
Blindness	Cataracts	Glaucoma
High BP	Macular Degeneration	Thyroid Disease
Other:		

PERSONAL MEDICAL HISTORY (circle all that apply)

Anemia	Cancer	Diabetes: Type 1/2/Pre
GERD	Heart Disease	Hypertension
Lupus	Thyroid Disease	Asthma
COPD	Hepatitis	Kidney Disease
Osteoporosis	Shingles/Chicken Pox	Rheumatoid Arthritis
Depression	Epilepsy	Migraine
High Cholesterol	Liver Disease	Stroke

REVIEW OF SYSTEMS (circle if currently experiencing)

General: Fever / Fatigue / Weight Loss / Loss of Appetite

HEENT: Hearing Loss / Sore Throat / Runny Nose

Cardiovascular: Chest Pain / Swelling of Feet / Shortness of Breath

Respiratory: Cough / Wheezing

GI: Nausea / Diarrhea / Abdominal Pain

Musculoskeletal: Joint Pain / Muscle Aches / Paralysis of Extremities / Difficulty Laying Flat

Neurological: Dizziness / Weakness / Headaches / Paralysis

Endocrine: Excessive Thirst / Frequent Urination / Heat Intolerance / Cold Intolerance

Genitourinary: Pain / Burning on Urination / Blood in Urine

Integumentary: Rash / Change in Mole

Hematology/Oncology: Easy Bruising / Prolonged Bleeding

PATIENT CERTIFICATION & SIGNATURE

I certify that the above information is correct to the best of my knowledge.

Signature: _____ **Date:** _____

AUTHORIZATION TO DISCUSS HEALTH INFORMATION

Brian J. Mihok, D.O., Inc.

Patient Name: _____ DOB: _____

I authorize Brian J. Mihok, D.O., Inc. to discuss my medical and/or billing information with the following individual(s). This allows us to communicate with family members, caregivers, or others involved in your care regarding appointments, treatment, test results, prescriptions, or billing.

AUTHORIZED INDIVIDUALS

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

VOICEMAIL AUTHORIZATION

Please select one:

__ YES, the office may leave detailed voicemail messages regarding appointments, test results, treatment, and billing.

____ NO, the office may only leave a callback request without detailed information.

PATIENT RIGHTS

I understand that:

• This authorization is voluntary.
• I may revoke this authorization at any time by submitting a written request to the office.
• Revocation will not apply to information already released based on this authorization.
• Information shared with an authorized individual may be redisclosed by that individual and may no longer be protected under HIPAA.

PATIENT CERTIFICATION & SIGNATURE

I certify that the above information is correct to the best of my knowledge.

Signature: _____ **Date:** _____

Office Use Only: Staff Initials: _____ Date Received: _____

FINANCIAL POLICY

Brian J. Mihok, D.O., Inc.

Patient Name: _____ DOB: _____

PATIENT RESPONSIBILITY

As a patient of this practice, you are responsible for understanding your insurance benefits and for payment of all charges not covered by your insurance plan. We will file claims on your behalf as a courtesy; however, the balance is ultimately your responsibility.

COPAYS, DEDUCTIBLES & COINSURANCE

- **Copays** are due at the time of service.
- **Deductibles** must be met before insurance pays. You are responsible for any unmet portion.
- **Coinsurance** is your share of costs after the deductible is met (e.g., 20% of allowed charges).
- If your insurance requires a **referral or prior authorization**, it is your responsibility to obtain it before your appointment.

NON-COVERED SERVICES & INSURANCE BALANCES

- Services not covered by your plan are your responsibility and payment is due at time of service.
- Balances remaining after insurance processing are due within 30 days of statement.
- Accounts over 90 days past due may be subject to collection action.

REFRACTION FEE - $30

A refraction is the portion of an eye examination used to determine your glasses prescription.

Medicare and most medical insurance plans do not cover refraction services.

If a refraction is performed during your visit, a $30 fee will be collected regardless of insurance coverage.

Complete practice policies provided by staff upon request.

PATIENT CERTIFICATION & SIGNATURE

I have read and understand the financial policy. I agree to be responsible for all charges not paid by my insurance.

Signature: _____ **Date:** _____

Office Use Only: Staff Initials: _____ Date Received: _____