Eye Center of Atlanta , P.C

Appointment Check In Form

Date: _____

PATIENT INFORMATION

Name: (Please Print)

Address:

City: **State:** **Zip:**

Home Phone #:

Cell Phone #:

Would you like to receive text messages/reminders to your cell phone? ___ Yes ___No

Email:

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:

Phone Number #:

Relationship:

PRIMARY CARE DOCTOR

Name:

INSURANCE INFORMATION

1. **Primary Insurance:** **Co-Pay:**
2. **Secondary Insurance:**
3. **Vision Insurance:**

PHARMACY INFORMATION:

Pharmacy Name:

Phone Number #: **Fax #:**

Address:

City: **State:** **Zip:**

PATIENT SIGNATURE:

Signature: **Date:**

Medical History

Date : _____ (Valid for one year from date)

Name (Last, Middle, First): _____ **DOB:** _____ **AGE:** _____ **M / F**

Referral Doctor: _____

Family Physician: _____

Past Eye History: (List all surgery/medications in the box on the right)

Family History: Glaucoma Macular Degeneration Cataracts
Other: _____

Social History: Smoking Alcohol Blood Transfusion?

Does your Vision limit any of your daily living/activities? Yes No

Occupation: _____

Females: ARE YOUR PREGNANT or NURSING? Yes No

Do you have or have had any of the following:

Y / N **Endocrine** (Diabetes, Thyroid, etc)
Y / N **Cardiovascular** (High BP, High Cholesterol, racing pulse, etc)
Other:_____
Y / N **Respiratory:** (Congestion, wheezing, short of breath, asthma, emphysema, etc)
Other:_____
Y / N **Neurological:** (headaches/migraines/MS/stroke/paralysis/seizures)
Y / N **Psychiatric:** (anxiety, depression, insomnia)
Y / N **Blood/Lymph:** (Anemia, bleeding, hepatitis, sickle cell, HIV+ AIDS, Cholesterolemia)
Y / N **Muscles/Bones,** Joints: (joint pain, stiffness, swelling, arthritis, cramps, etc)
Y / N **Gastrointestinal:** (ulcer, hernia, stomach upset, chronic diarrhea)
Y / N **Allergic/Immunological:** (lupus, sarcoid, sneezing, swelling, itching, redness, etc)
Y / N **Kidney/Bladder/Genital:** (frequent or painful urination, yellow jaundice, etc)
Y / N **Skin:** (growths, rash, etc)
Y / N **Ear/Nose/Throat:** (hard of hearing, chronic sinus, cough, surgery)
Y / N **Cancer:** (What Type?_____)
Are your currently receiving Treatment? _____
Y / N **General Constitution:** fever, unusual weight gain/loss, tired, etc)
Y / N **Other Medical History or Surgery:** _____

Y / N **Allergies (Please list all allergies in the box on the right)**

Are your currently interested in: Glasses Sunglasses Contacts LASIK

Patient Signature: _____ **Date:** _____

EYE SURGERY
1)
2)
3)
4)
4)

EYE MEDICATIONS (Prescribed or OTC)
1)
2)
3)
4)
5)

OTHER MEDICATIONS (Prescribed or OTC)
1)
2)
3)
4)
5)
6)
7)
8)
9)
10)
11)
12)
13)

ALLERGIES
1)
2)
3)
4)
5)
6)

Eyes *

- Previous Surgery ☐ YES ☐ NO
- Contact Lens ☐ YES ☐ NO
- Pain ☐ YES ☐ NO
- Double Vision ☐ YES ☐ NO
- Glaucoma ☐ YES ☐ NO
- Cataracts ☐ YES ☐ NO
- Macular Degeneration ☐ YES ☐ NO
- Dry Eyes ☐ YES ☐ NO
- Loss of Vision ☐ YES ☐ NO
- Blurred Vision ☐ YES ☐ NO
- Distorted Vision/Halos ☐ YES ☐ NO
- Loss of Side Vision ☐ YES ☐ NO

Ear, Nose, and Throat *

- Hard of Hearing ☐ YES ☐ NO
- Ringing in Ears ☐ YES ☐ NO
- Vertigo ☐ YES ☐ NO

Cardiovascular *

- Chest Pain ☐ YES ☐ NO
- Dizziness ☐ YES ☐ NO
- Fainting Spells ☐ YES ☐ NO
- Shortness of Breath ☐ YES ☐ NO
- Irregular Heart Beat ☐ YES ☐ NO
- Difficulty Lying Flat ☐ YES ☐ NO

Constitutional *

- Fatigue/Weakness ☐ YES ☐ NO
- Fever ☐ YES ☐ NO
- Weight Gain/Loss ☐ YES ☐ NO
- Fever, Weight Loss/Gain ☐ YES ☐ NO

Respiratory *

- Cough ☐ YES ☐ NO
- Congestion ☐ YES ☐ NO
- Wheezing ☐ YES ☐ NO
- Asthma ☐ YES ☐ NO
- Chronic Bronchitis ☐ YES ☐ NO
- Emphysema ☐ YES ☐ NO

Gastrointestinal *

- Heartburn ☐ YES ☐ NO
- Nausea/Vomiting ☐ YES ☐ NO
- Jaundice/Hepatitis ☐ YES ☐ NO

Genito-Urinary *

- Pain/Difficulty ☐ YES ☐ NO
- Blood in Urine ☐ YES ☐ NO
- History of Kidney Stones ☐ YES ☐ NO
- History of STD's ☐ YES ☐ NO

Psychiatric *

- Anxiety/Depression ☐ YES ☐ NO
- Mood Swings ☐ YES ☐ NO
- Difficulty Sleeping ☐ YES ☐ NO

Endocrine *

- Increased Thirst ☐ YES ☐ NO
- Increased Hunger ☐ YES ☐ NO
- Increased Urination ☐ YES ☐ NO
- Increased Sweating ☐ YES ☐ NO
- Fingernail Changes ☐ YES ☐ NO

Blood/Lymphnodes *

- Easy Bruising ☐ YES ☐ NO
- Gums Bleed Easily ☐ YES ☐ NO
- Prolonged Bleeding ☐ YES ☐ NO
- Heavy Aspirin Use ☐ YES ☐ NO

MusculoSkeletal *

- Stiffness ☐ YES ☐ NO
- Arthritis ☐ YES ☐ NO
- Joint Pain/Swelling ☐ YES ☐ NO

Skin *

- Rash/Sores ☐ YES ☐ NO
- Lesions ☐ YES ☐ NO
- Hives/Eczema ☐ YES ☐ NO

Neurological *

- Seizures ☐ YES ☐ NO
- Weakness/Paralysis ☐ YES ☐ NO
- Numbness ☐ YES ☐ NO
- Tremors ☐ YES ☐ NO
- Headaches ☐ YES ☐ NO

Immunologic *

- Hives ☐ YES ☐ NO
- Itching ☐ YES ☐ NO
- Runny Nose ☐ YES ☐ NO
- Sinus Pressure ☐ YES ☐ NO

Notes:

Eye Center of ATLANTA, P.C.

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full length notice is posted in the reception area and a copy of the full length is available for you at the checkout desk.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY HAVE ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you and we are committed to protecting your information about you. As our patient, we create medical records about your health, our care for you, and the services/and or items we provide to you as our patient. By law, we are required to make sure that your information is protected and kept confidential.

• Please find some examples where we use or disclose your information (for more detail, please refer to the complete Notice of Privacy Practices) • For medical treatment • For emergency situations • For Workers Compensation programs • To obtain payment for your services	• For research • For quality assurance • For appointments • Allow practice to flow efficiently • In response to issue arising from legal matters

You , as the patient, have certain rights regarding the information we maintain about you. All requests must be made in writing, with a 48 hour notice, no exceptions. Our medical records staff/department will assist you with the written requests. These rights include:

• The right to inspect and copy your file (see rates that apply) • The right to amend • The right to an accounting of disclosures • The right to a paper copy of this notice	• The right to request restrictions • The right to request confidential communication

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Our Notice of Privacy Practices provides information about how we use and disclose protected health information about you. Your have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice can change. If we change our notice, you may obtain a revised copy of this by contacting the office. You have the right to inspect that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you (or your representative) consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name (Print):

~^ SIGNATURE ^~

Signed: ~^ DATE ^~

Eye Center of ATLANTA, P.C.

FINANCIAL AND MANAGED CARE POLICIES

We, at Eye Center of Atlanta, P.C., participate with many insurance plans as a convenience to our patients. However, we expect our patients to pay their share for our services, as specified in your benefits contract. We will help you determine theses amounts.

- Payment of coinsurance, deductibles, cop-pay or private pay is due at the time of service.

- **Medicare Coverage**: I acknowledge that I may be responsible for certain charges at the time of my visit or any related claims due to either the provisions of Medicare or lack of Medicare's policy to cover these charges. I also understand Medicare **MAY NOT** pay for particular items or services. I am fully responsible for non-covered services and procedures.

- **Commercial Coverage**: I acknowledge that I may be responsible for certain charges at the time of my visit or any related claims due to the provisions of my insurance or insurance policy to cover these charges. I also understand my insurance **MAY NOT** pay for particular items or services. I am fully responsible for non-covered services and procedures.

- **Private Pay**: I understand payment is due in full at the time of service.

- I understand I can appeal my insurance's payment decision

By signing this form, I understand that any financial responsibility on my behalf is to be resolved at the time of service. I also understand that I am responsible both for any fees remaining unpaid by my insurance carrier after 60 days and for collection costs and attorney fees required to collect those fees.

By signing this form, I understand that I grant permission for Eye Center of Atlanta, P.C. to file claims to my insurance carrier for services rendered during my consultation visit.

Patient Name (Print):

~^ SIGNATURE ^~

Signed: ~^ DATE ^~