

# Angel Oak Eye Center

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Male  Female  Single  Married  Divorced  Widowed

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_

Race:  White  Black or African American  Multiracial  Amer. Indian/Alaskan Native

Hispanic  Asian  Native Hawaiian or Other Pacific Island  Decline to Specify

Email: \_\_\_\_\_

Retired  Unemployed  Student  Employed Employer: \_\_\_\_\_ Wk Phone: \_\_\_\_\_

\* If patient is a child: Parent Name: \_\_\_\_\_ Parent DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent Address(if different): \_\_\_\_\_ Parent SSN: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_

Primary Insurance: \_\_\_\_\_ ID # \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID # \_\_\_\_\_

Primary Insurance Cardholder Name: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ Dr's Phone: \_\_\_\_\_

Last Medical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Eye Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Patient Medical History

List any **medications** you take (including oral contraceptives, aspirin, over the counter medications and home remedies):  NONE \_\_\_\_\_

\_\_\_\_\_

Do you have any allergies to medications?  No  Yes-Explain: \_\_\_\_\_

List all major injuries, surgeries and/or hospitalizations you have had:  NONE \_\_\_\_\_

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infections or eye injury:  NONE \_\_\_\_\_

Are you pregnant and/or nursing?  No  Yes

Do you wear glasses?  No  Yes If yes, how old is your present pair of lenses? \_\_\_\_\_

Do you wear contact lenses?  No  Yes If yes, how old is your present pair of lenses? \_\_\_\_\_

Type of contact lenses:  Rigid  Soft  Extended Wear  Other Are they comfortable?  No  Yes

Are you interested in contact lenses today?  No  Yes If yes, what kind of contact lenses are you interested in?

Dailies  2 Wk Disposable  Monthly Disposable  Bi-Focal Lenses  Mono-Vision  Colors  Sleep In

### Family History

Please note any family history (parents, grandparents, siblings, children) for the following conditions:

DISEASE/CONDITION	NO	YES	DISEASE/CONDITION	NO	YES
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>

**HOW DID YOU HEAR ABOUT OUR OFFICE?** \_\_\_\_\_

**SOCIAL HISTORY** This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.  Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive?  no  yes If yes, do you have visual difficult when driving?  no  yes If yes, please describe: \_\_\_\_\_

Do you use tobacco products?  no  yes If yes, type/amount/how long: \_\_\_\_\_

Do you drink alcohol?  no  yes If yes, type/amount/how long: \_\_\_\_\_

Do you use illegal Drugs?  no  yes If yes, type/amount/how long: \_\_\_\_\_

Have you ever been exposed to or infected with:  Hepatitis  HIV  NO

**REVIEW OF SYSTEMS**

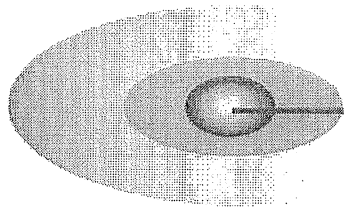
Do you currently, or have you ever had any problems in the following areas:

CONSTITUTIONAL	NO	YES	EARS, NOSE, MOUTH, THROAT	NO	YES
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL			Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>
EYES			RESPIRATORY		
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision Dist./Near	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR / CARDIOVASCULAR		
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL		
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY		
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	BONES / JOINTS / MUSCLES		
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Stye or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC / HEMATOLOGIC		
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE			ALLERGIC / IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			

\*All the above information (and from page 1) was written to the best of my knowledge or was completed by a parent, legal guardian or the Front Desk by my request. I understand that I will be responsible for the payment of Professional Services and Prescription Glasses and/or Contact Lenses once they have been dispensed, unless charges have been billed to my insurance.

**Patient (Or Guardian) Signature:** \_\_\_\_\_

**Date:**        /        /



# Angel Oak Eye Center

**\*\*\*PLEASE INITIAL AND SIGN BELOW\*\*\***

                     Initials      **Medicare Lifetime Signature on File (for Medicare patients)**  
 I request that payment of authorized Medicare benefits be made on my behalf directly to this practice for any services furnished me by the physician. I authorize the release of any medical or other information necessary for processing claims to the Center of Medicare and Medicaid Services.

                     Initials      **Private Insurance Authorization for Assignment of Benefits/Info Release**  
 I authorize the payment of medical benefits be made on my behalf directly to this practice for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I authorize the release to my insurance company information concerning healthcare, advice or treatment provided to me necessary for processing insurance claims.

                     Initials      **Agreement of Financial Responsibility for Non-Covered Services**  
 Routine and Preventive services are not covered by most insurance plans. Your insurance plan may not cover your visit today if you do not have a medical complaint or significant problem/abnormality. In the event that services provided are denied as routine, preventive, pre-existing or non-covered, you will be responsible for the balance.

                     Initials      **HIPAA Notice of Privacy Practices Acknowledgment**  
 I have received , read and understand your Notice of Privacy Practices. I understand that this information will be used to carry out treatment, payment and normal healthcare operations of the practice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

                     Initials      **Authorization to Release and/or Obtain Medical Records**  
 I hereby authorize all physicians participating in my healthcare, and Angel Oak Eye Center's physicians, the release, use and disclosure of my entire medical record by mail, phone and fax to carry out my treatment, payment and healthcare operations.

                     Initials      **\*Missed Appointments:** We take this subject very seriously. There is a **\$25.00 charge** for no-show appointments or cancelling without a 24 hour notice.

**I am giving permission to discuss my healthcare treatment with:**

Spouse Name: \_\_\_\_\_ Phone# \_\_\_\_\_

Family Member Name: \_\_\_\_\_ Phone# \_\_\_\_\_

Friend Name: \_\_\_\_\_ Phone# \_\_\_\_\_

Other Name: \_\_\_\_\_ Phone# \_\_\_\_\_

**Patient (Or Guardian) Signature** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_