

• 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 Asian
 Hispanic Native Hawaiian or Other Pacific Island Decline to Specify Other _____

• 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 _____

• Preferred Pharmacy Name/Address: _____ Phone#: _____

• Do you have any allergies to medications? No Yes-Explain: _____

• List all major injuries, surgeries and/or hospitalizations you have had: NONE _____

• Check any of the following that you have had: Crossed Eyes Lazy Eyes Drooping Eyelids

Glaucoma Retinal Disease Cataracts Eye Injury Eye Infections NONE

• Are you pregnant and/or nursing? No Yes

• Do you wear glasses now? 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 Disp. Monthly Disp. Bi-Focal Mono-Vision Colors Sleep In Not Sure

Family History

• Please note any family history (parents, grandparents, siblings, children or yourself) 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"/>

• Patient Name: _____

• **HOW DID YOU HEAR ABOUT OUR OFFICE?** _____

• **SOCIAL HISTORY** The information in this section is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. Yes, I 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: HIV: No Yes Hepatitis: No Yes

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		
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			

*All of the above information (and from page 1) was written to the best of my knowledge or was completed by a legal guardian or the Front Desk by my request.

I understand that Angel Oak Eye Center does not guarantee the accuracy of benefit information given by insurance companies. I understand that financial responsibility is mine, and not the responsibility of my insurance company.

Patient (Or Guardian) Signature: _____

Date: / / _____



Angel Oak Eye Center

Initial _____ 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.

Initial _____ 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 authorize the release to my insurance company any information concerning healthcare, advice or treatment provided to me necessary for processing insurance claims.

Initial _____ Agreement of Financial Responsibility for Non-Covered Services

Routine and Preventive services are not covered by most medical 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.

***It is your responsibility to verify your insurance coverage and benefits before your appointment.

Initial _____ 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.

Initial _____ 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.

Initial _____ Missed Appointments: 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# _____

*By signing below, I am agreeing that I have read and understand everything above.

Signature: _____ Date: ____ / ____ / ____