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 ☐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	☐	☐	Cancer	☐	☐
Cataract	☐	☐	Diabetes	☐	☐
Crossed Eyes	☐	☐	Heart Disease	☐	☐
Glaucoma	☐	☐	High Blood Pressure	☐	☐
Macular Degeneration	☐	☐	Kidney Disease	☐	☐
Retinal Detachment/Disease	☐	☐	Lupus	☐	☐
Arthritis	☐	☐	Thyroid Disease	☐	☐

• Patient Name:_____ DOB:____/____/_____

• **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:

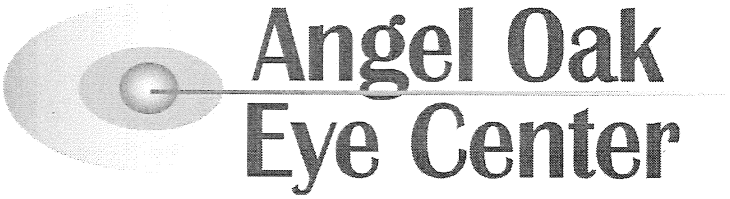
CONSTITUTIONAL	NO	YES
Fever, Weight Loss/Gain	□	□
INTEGUMENTARY (Skin)	□	□
NEUROLOGICAL		
Headaches	□	□
Migraines	□	□
Seizures	□	□
EYES		
Loss of Vision	□	□
Blurred Vision Dist./Near	□	□
Distorted Vision/Halos	□	□
Loss of Side Vision	□	□
Double Vision	□	□
Dryness	□	□
Mucous Discharge	□	□
Redness	□	□
Sandy or Gritty Feeling	□	□
Itching	□	□
Burning	□	□
Foreign Body Sensation	□	□
Excess Tearing/Watering	□	□
Glare/Light Sensitivity	□	□
Eye Pain or Soreness	□	□
Chronic Infection of Eye or Lid	□	□
Stye or Chalazion	□	□
Flashes/Floaters in Vision	□	□
Tired Eyes	□	□
ENDOCRINE		
Thyroid/Other Glands	□	□
Diabetes	□	□

EARS, NOSE, MOUTH, THROAT	NO	YES
Allergies/Hay Fever	□	□
Sinus Congestion	□	□
Runny Nose	□	□
Post-Nasal Drip	□	□
Chronic Cough	□	□
Dry Throat/Mouth	□	□
RESPIRATORY		
Asthma	□	□
Chronic Bronchitis	□	□
Emphysema	□	□
VASCULAR / CARDIOVASCULAR		
Heart Pain	□	□
High Blood Pressure	□	□
Vascular Disease	□	□
GASTROINTESTINAL		
Diarrhea	□	□
Constipation	□	□
GENITOURINARY		
Genitals/Kidney/Bladder	□	□
BONES / JOINTS / MUSCLES		
Rheumatoid Arthritis	□	□
Muscle Pain	□	□
Joint Pain	□	□
LYMPHATIC / HEMATOLOGIC		
Anemia	□	□
Bleeding Problems	□	□
ALLERGIC / IMMUNOLOGIC	□	□
PSYCHIATRIC	□	□

*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**: / /



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.

Print Patient Name:_____ **DOB:**____/____/_____

Patient (or Guardian) Signature:_____ Date:____/____/_____