Angel Oak Eye Center

☐**Male** ☐**Female** Date: _____/_____/_____

☐**Single** ☐**Married** ☐**Divorced** ☐**Widowed**

Patient Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

Email: _____

☐**Retired** ☐**Unemployed** ☐**Student** ☐**Employed** Employer: _____

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: _____/_____/_____

If patient is a child: Parent Name: _____ **Parent DOB:** ____/____/_____

Parent Address(if different): _____ **Parent SSN:** _____-_____-_____

Patient Medical History

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

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

_____

_____

_____

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 Week Disposable ☐ Monthly Disposable ☐ Bi-Focal Lenses ☐ Mono-Vision ☐ Colors ☐ Sleep In

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) 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:_____

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:

	NO	YES
CONSTITUTIONAL		
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	□	□

	NO	YES
EARS, NOSE, MOUTH, THROAT		
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 the above information 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.

Signature: _____ **Date:** / /

Angel Oak Eye Center

PLEASE INITIAL AND SIGN BELOW

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/Information 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 Routine, Preventive and 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

HIPPA 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 our my treatment, payment and healthcare operations. _____ Signature Required

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 acknowledge that this form has been read in full and explained as necessary.

_____/_____/_____ _____
Date Patient Name (Please Print)

_____/_____/_____ _____
Patient Date of Birth Signature of Patient or Personal Representative