DOSS EYE CARE

Dr. Gene Doss
1115 South Elm Street
Commerce, GA 30529
Phone (706) 335-5139

Welcome to Doss Eye Care. Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence that you placed in us. Please take a moment to complete all of the following information to ensure that we are able to provide the best care for your specific needs and requirements. If you have any questions, please do not hesitate to ask one of our staff.

TODAY'S DATE _____ **DATE OF BIRTH** _____

NAME _____ **SOCIAL SECURITY NUMBER** _____

ADDRESS _____ **SEX** _____ **MALE** _____ **FEMALE**

CITY _____ **STATE** _____ **ZIP** _____

PHONE -HOME _____

PHONE -WORK _____

PHONE -CELL _____

Communications - We now have multiple ways of contacting our patients. Please select ALL of the ways that you prefer that we contact you.

Home	Work	Cell	Email	Text	Mail

EMAIL ADDRESS _____

MARITAL STATUS
___ Married
___ Single
___ Other

EMPLOYMENT/SCHOOL STATUS
___ Employed Full Time
___ Employed Part Time
___ Student Full Time
___ Student Part Time
___ Not Employed
___ Retired
___ Homemaker
___ Active Military
___ Disabled

Employer/School _____ **Position/Grade** _____

Employer Address & Phone # _____

PLEASE LIST ANY MEMBERS OF YOUR HOUSEHOLD WHO COME TO OUR OFFICE: _____

_____

FAMILY PHYSICIAN NAME _____ **LOCATION** _____

PHARMACY PREFERENCE _____ **LOCATION** _____

REASON FOR TODAY'S VISIT? _____

(medical insurance can only be billed for medically necessary visit)

Do you currently wear glasses?	**Yes**	**No**	**Would you be interested in contacts today?**	**Yes**	**No**
Do you currently wear contacts?	**Yes**	**No**	**Would you be interested in LASIK?**	**Yes**	**No**

PLEASE CHECK ALL THAT APPLY TO YOU

PRESENT OCULAR HISTORY:

___ Age related macular degeneration
___ Blurred vision
___ Bothersome night glare
___ Burning
___ Cataracts
___ Conjunctivitis
___ Diabetic retinopathy
___ Discharge
___ Double vision
___ Eye pain
___ Eye strain
___ Glaucoma
___ Headache
___ Iridocyclitis
___ Itching
___ Poor Night Vision
___ PVD - Floaters
___ Redness
___ Retina
___ Severe sensitivity to light
___ Tearing
___ Total loss of vision

GENERAL

___ Developmental Disabilities
___ Cancer
___ Fatigue Syndrome

EARS/NOSE/THROAT

___ Hearing Loss
___ Sinusitis
___ Dry Mouth
___ Laryngitis

NEUROLOGY

___ Multiple Sclerosis
___ Epilepsy
___ Cerebral Palsy
___ Tumor
___ Stroke/CVA
___ Migraine

PSYCHIATRIC

___ Depression
___ Attention Deficit
___ Anxiety Disorder
___ Bipolar Disorder

CARDIOVASCULAR

___ Hypertension
___ Stroke/CVA
___ Heart Disease
___ Vascular Disease
___ Congestive Heart Failure

RESPIRATORY

___ Cigarette Smoker
___ Asthma
___ Bronchitis
___ Emphysema
___ Chronic Obstruction
___ Sleep Apnea

GASTROINTESTINAL

___ Crohn's
___ Colitis
___ Ulcer
___ Acid Reflux
___ Celiac Disease

GENITOURIARY

___ Kidney Disease
___ Prostate Disease/Cancer
___ STD-Herpetic/Chlamydia
___ Benign Prostate Hypertrophy
___ Pregnant
___ Nursing
___ Herpes
___ Chlamydia

MUSCULOSKELETAL

___ Osteoarthritis
___ Arthritis
___ Fibromyalgia
___ Muscular Dystrophy
___ Ankylosing Spondylitis
___ Osteoporosis
___ Gout

INTEGUMENTARY

___ Eczema
___ Rosacea
___ Psoriasis
___ Herpes Simplex/Cold Sores
___ Herpes Zoster/Shingles

ENDOCRINE

___ Type 2 Diabetes
___ Type 1 Diabetes
___ Thyroid Dysfunction
___ Hormonal Dysfunction

HEMOTOLOGIC/LYMPHATIC

___ Anemia
___ Large-Volume Blood Loss
___ Ulcer
___ High Cholesterol

ALLERGIC/IMMUNE

___ Drug Allergies
___ Environmental Allergies
___ Rheumatoid Arthritis
___ Lupus
___ Sjogren's Syndrome

CURRENT MEDICATIONS TAKEN

___ None Taken

_____
_____
_____
_____
_____
_____
_____
_____

MEDICATION ALLERGIES

___ No Known Allergies

_____
_____
_____
_____

OTHER ALLERGIES

___ No Known Allergies
___ Latex Allergies

_____
_____

PAST OCULAR HISTORY

___ Glaucoma
___ Cataract
___ Surgery
___ Patching
___ Inflammatory Disorder
___ Strabismus
___ Amblyopia
___ Retinal Degeneration
___ Retinal Hole
___ Retinal Detachment
___ Keratoconus
___ Injury
___ Dry Eye

SOCIAL HISTORY

Alcohol Use ___ Yes ___ No
If yes, # ____ per day/ week / month

Tobacco Use ___ Yes ___ No
___ Some Days ___ Everyday
___ Never ___ Former
Amount _____ per day / week

FAMILY MEDICAL HISTORY

Mark all that apply to immediate family and list relationship
___ Diabetes
Relationship _____
___ Hypertension
Relationship _____

FAMILY OCULAR HISTORY

___ Macula Degeneration
Relationship _____
___ Glaucoma
Relationship _____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICE

I have been presented with the Notice of Privacy Practices for Doss Eye Care and a copy can be provided upon request. (Copy is posted to the right of the check in window and an individual copy can be requested)

ACKNOWLEDGEMENT OF FINANCIAL POLICY STATEMENT

- There are two types of health insurance that will help pay for your eye care services and products. You may have both, and our practice accepts both:
  Vision Care Plans (such as VSP, EyeMed, Superior Vision, VCP and Spectera)
  Medical Insurance (such as Blue Cross/Blue Shield, United HealthCare and Medicare)

- Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management, or treatment of eye diseases. Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.

- We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays, or non-covered services as allowed by the insurance contract.

- We are happy to help you verify your insurance benefits. If you are not eligible or are eligible for less than full coverage, ***your signature indicates that you agree to be financially responsible for the balance not paid by your plan.*** Our office makes every effort to verify your benefits but ***verification of benefits is not a guarantee of payment.*** We reserve the right to bill you directly for services and materials if we have not received a payment or a denial from your insurance company within 30 days of the filing date.

  - I understand that I am responsible for my bill once professional services have been rendered.
  - I authorize use of this form on all my insurance submissions.
  - I authorize my doctor to act as my agent in helping me obtain payment from insurance companies.
  - I authorize direct payment to my doctor and permit a copy of this authorization to be used in place of the original.

- Payment in full is expected at time of order. All glasses and contacts must be picked up within 90 days of order placement. After this time all materials will be returned to stock and all deposits will be lost. Materials cannot be dispensed until paid in full.

- Contact Lens Evaluation Fee – The contact lens evaluation fee is an additional charge and separate from your comprehensive eye exam. Contact lens services are non-refundable. Contact lenses may be exchanged in case of prescription change, provided that such change is made within six months of the exam date and the boxes are unopened and not damaged. In addition to your routine eye exam a contact lens evaluation and fitting includes:

  - Determination of contact lens prescription
  - Measurement of the cornea
  - Evaluation of contact lens fit and comfort
  - Assessment of the contact lens fit, the cornea, tear film, eyelids
  - Information about contact lens care, safety and solutions
  - One pair of trial contacts lens (some exclusions apply for specialty fits)
  - 1 week follow up
  - Contact lens prescription valid for one year

- Returned Checks – There will be a $30.00 service charge on all returned checks. Payment for returned checks is due upon notice of returned check and payable only by cash, money order or credit card. Checks cannot be accepted for payment on balances with returned check fees.

- Collections Policy – All balances are due at the time of service on or before the statement due date. Balances not paid by the statement due date may be reported to United Collection Firm of Georgia and documented on your credit report. All collection fees are your responsibility. Accounts sent to United Collection Firm of Georgia become public record and will show that you received treatment in our office.

I have read and understand the present office policies. My signature indicates that I agree to be financially responsible for the professional fees for today's medical or routine eye evaluation as well as any purchased materials. I am aware that payment is expected on the same day as professional services have been rendered and before ophthalmic materials, such as contacts or glasses, can be ordered.

_____ _____

Signature of Patient or Patient Representative if a Minor Date