eye care

FOR YOUR EYES ONLY

Last Name: _____ **First Name:** _____**Male / Female**

Name of Spouse (If Married) _____ **Parents Name (If Child)** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Phone # (_____) _____ **Cell Phone #** (_____) _____ **Work Phone #** (____) _____

Fax # (____) _____ **E-Mail** _____

Date of Birth _____ **Social Security #**_____/____/_____ **Occupation** _____

Date of last eye exam: _____ **Reason for Today's Visit:** _____

Medical History

Do you have any allergies to medication or other? YES / NO If yes, please explain: _____

List medications you take (including oral contraceptives, aspirin, over-the-counter medications, & home remedies):

_____

_____

List all major injuries, surgeries, and/or hospitalizations you have had: _____

_____

_____

Are you pregnant or nursing? (Please circle) YES / NO

Family History

Please note any family history including but not limited to: parents, grandparents, siblings, children; living or deceased for the following conditions:

Disease/Condition	Circle One	Relationship
Blindness	NO YES	
Glaucoma	NO YES	
Crossed Eyes	NO YES	
Retinal Detachment	NO YES	
Macular Degeneration	NO YES	
Heart Disease	NO YES	
High Blood Pressure	NO YES	
Cancer	NO YES	
Diabetes	NO YES	
Other	NO YES	

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Social History

This information is kept strictly confidential.

Do you use any of the following? If yes, please explain what type, amount used and how long the item has been used.

Tobacco Products	**NO**	**YES**	_____
Alcohol	**NO**	**YES**	_____
Illegal Drugs	**NO**	**YES**	_____

Have you ever been exposed to or infected with any of the following (Please circle all that apply):

Gonorrhea Hepatitis HIV Syphilis

Review of Systems

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

	NO	YES		NO	YES
Neurological			**Vascular/Cardiovascular**		
Headaches			Diabetes		
Migraines			Heart Pain		
Seizures			High Blood Pressure		
Eyes			Vascular Disease		
Tired Eyes when reading			**Gastrointestinal**		
Lose place when reading			Chronic Diarrhea		
Miss- read short words			Chronic Constipation		
Blurred vision			**Genitourinary**		
Distorted vision/Halos			Genitals/Kidney/Bladder		
Loss of side vision			**Bones/Joints/Muscles**		
Double Vision			Rheumatoid Arthritis		
Dryness			Muscle Pain		
Mucous Discharge			Joint Pain		
Redness			**Lympathic/ Hemotologic**		
Sandy or Gritty sensation			Anemia		
Itching			Bleeding Problems		
Burning			**Ear, Nose, Mouth, Throat**		
Foreign Body sensation			Allergies/ Hay Fever		
Excess Tearing/ Watering			Sinus Congestion		
Glare/ Light Sensitivity			**Endocrine**		
Eye Pain or Soreness			Thyroid/ Other Glands		
Chronic Infection of Eye or Lid			**Respiratory**		
Sties or Chalazion			Asthma		
Flashes or Floaters in Vision			Emphysema		
Loss of vision					
Eye injury/surgery					
Crossed Eye					

If you suffer from any conditions mentioned on the list above or have a condition not listed, please explain and list medications: _____

_____

5851 S. Vickery Street · Vickery Village · Cumming, GA ·

(678) 648-5185

eye care

FOR YOUR EYES ONLY

STATEMENT OF FINANCIAL RESPONSIBILITY

PRINT PATIENT NAME: _____

1. **PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION**
   I hereby authorize and direct payment of my vision and/or medical benefits to For Your Eyes Only – Eye Care, for any services furnished to me by For Your Eyes Only – Eye Care. I authorize the holder of vision and/or medical information regarding me to release any information, including diagnosis and the records of any treatment or examination rendered to my dependent(s) or me during the period of such vision and/or medical services to third party payers and/or health practitioners. In the event that my vision and/or health plan determines a product(s) and/or service(s) to be "not covered", I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid products and/or services rendered on my behalf or my dependents, including any fees for collection services needed.

   _____ _____
   DATE: Signature of Patient (or responsible party)

2. **PAYMENT**
   I hereby assume responsibility to pay the costs of all products and/or services provided by For Your Eyes Only – Eye Care and its representatives to the patient.

   _____ _____
   DATE: Signature of Patient (or responsible party)

3. **AUTHORIZATION OF PAYMENTS**
   I understand that For Your Eyes Only – Eye Care will assist me in submitting my claim to my insurance carrier. I hereby authorize payment directly to For Your Eyes Only – Eye Care and its representatives of vision and/or medical benefits, otherwise payable to me, for the services provided. I understand that I am financially responsible for my vision and/or health insurance deductibles, coinsurance and non-covered services.

   _____ _____
   DATE: Signature of Patient (or responsible party)

4. **MEDICARE LIFETIME SIGNATURE ON FILE**
   I request that payment of authorized Medicare benefits be made either to me or on my behalf to For Your Eyes Only – Eye Care for any products and/or services furnished me by For Your Eyes Only – Eye Care. I authorize any holder of vision and/or medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determination these benefits or the benefits payable for related services.

   _____ _____
   DATE: Signature of Patient (or responsible party)

Name of Vision Insurance Plan _____ Name of Primary Insured _____
Date of Birth of Primary Insured _____ ID _____

Name of Medical Insurance Plan _____ Phone # _____

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Patient Consent Form

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **For Your Eyes Only – Eye Care** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **For Your Eyes Only – Eye Care** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.
For Your Eyes Only – Eye Care reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request **For Your Eyes Only – Eye Care, 5851 S. Vickery St., Cumming GA 30040**.

With this consent, **For Your Eyes Only – Eye Care** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **For Your Eyes Only – Eye Care** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, **For Your Eyes Only – Eye Care** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **For Your Eyes Only – Eye Care** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **For Your Eyes Only – Eye Care** to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **For Your Eyes Only – Eye Care** may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable