SOUTHERN EYE CENTER

PLEASE COMPLETE BOTH SIDES

Step 1 PATIENT REGISTRATION

Patient (Ms., Mrs., Mr.) ______________________

Address ______________________

____
City State Zip

Home # __________ Cell # __________

Work # __________ May we text you? __________

Email Address ______________________

Sex ☐ M ☐ F Birthdate __________ Age ______

Race ☐ Black ☐ White ☐ Asian ☐ Other __________

Language Used ☐ English ☐ Spanish ☐ Other __________

Social Security Number ______________________

Occupation ______________________

Employer ______________________

Employer Address ______________________

Employer Phone ______________________

Parent/Spouse Name ______________________

Birthdate __________ SS # __________

Occupation ______________________

Spouse's Employer ______________________

How were you referred to us?

____

Check your method of payment:

Cash ☐ Check ☐ MC/Visa ☐ Amex ☐ Discover ☐

There is a $30 fee for NSF Checks.

Step 2 INSURANCE

Who is responsible for this account? ______________________

Relationship to Patient ______________________

Birthdate __________ SS # __________

Insurance Company ______________________

Member # __________ Group # __________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ______________________

Birthdate __________ SS # __________

Relationship to Patient ______________________

Insurance Company ______________________

Member # __________ Group # __________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with __________________ and assign directly to Southern Eye Center all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of the signature on all insurance submissions.

______________________ __________
Responsible Party Signature Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Southern Eye Center for services furnished me by Southern Eye Center. I authorize any holder of medical information about me to release to the Division of Medicare and Medicaid Services and its agents any information needed to determine those benefits payable for related services. **I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form,** or elsewhere on other approved claims forms or electronically submitted claims, **my signature authorizes releasing of the information to the insurer or agency shown.** In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______________________ __________
Beneficiary Signature Date

CONSENT FOR MEDICAL TREATMENT

Knowing that I am having a dilated eye examination or suffering from a condition requiring medical treatment, I do hereby voluntarily consent to such diagnostic procedures as are necessary in the judgement of the optometrist(s) in charge. I acknowledge that no guarantees have been made to me as to the results of examination or treatment in the hospital or office.

Signature ______________________
Patient or Person Authorized to Consent

Step 3 MEDICAL HISTORY QUESTIONNAIRE

PAST PERSONAL HISTORY

MEDICATIONS

- __________ ▪ __________
- __________ ▪ __________
- __________ ▪ __________

Drug Allergies ______________________

PRIMARY CARE PHYSICIAN INFORMATION

Name ______________________

Address ______________________

____

Phone Number __________ **Fax** __________

Pharmacies & Phone # 1) ______________________ **2)** ______________________

Describe all serious illnesses, injuries and surgeries:

____

____

FEES DUE UPON SERVICES RENEDERED

FEES FOR PRODUCTS ARE DUE UPON ORDERING AND DISPENSING

Step 3	MEDICAL HISTORY QUESTIONNAIRE (cont.)

FAMILY HISTORY

Please note any family members with the following disease/conditions: M-mother F-father S-sibling GP-grandparent

		YES	NO			YES	NO
Arthritis	____	☐	☐	Heart Disease	____	☐	☐
Blindness	____	☐	☐	Hypertension	____	☐	☐
Cancer	____	☐	☐	Kidney Disease	____	☐	☐
Cataracts	____	☐	☐	Lupus	____	☐	☐
Crossed Eyes	____	☐	☐	Macula Degen.	____	☐	☐
Diabetes	____	☐	☐	Retinal Disease	____	☐	☐
Glaucoma	____	☐	☐	Thyroid Disease	____	☐	☐

SOCIAL HISTORY

Health Habits
Check which substance you use and the consumption.

	YES	NO
Alcohol	☐	☐
Quantity:	________	
Drugs	☐	☐
Quantity	________	
Tobacco	☐	☐
Quantity	________	

Social History
Please indicate hobbies and interest:

	YES	NO
Computer	☐	☐
Fishing	☐	☐
Golfing	☐	☐
Hunting	☐	☐
Music	☐	☐
Reading	☐	☐

REVIEW OF SYSTEMS

Check the symptoms and /or conditions you currently have or have had in the past.

EYES	YES	NO	UNKNOWN
Blurred Vision	☐	☐	☐
Burning	☐	☐	☐
Cataracts	☐	☐	☐
Crossed Eyes	☐	☐	☐
Distorted Vision (Halos)	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Excess Tearing/ Watering	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Flashes/ Floaters in Vision	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Glaucoma	☐	☐	☐
Infection of Eye or Lid	☐	☐	☐
Itching	☐	☐	☐
Lazy Eye	☐	☐	☐
Loss of Vision	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Retinal Disease	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Stye or Chalazion	☐	☐	☐
BONE/JOINT/MUSCLE			
Arthritis	☐	☐	☐
Joint/Muscle Pain	☐	☐	☐
Polio	☐	☐	☐
CANCER			
Breast	☐	☐	☐
Lung	☐	☐	☐
Prostate	☐	☐	☐
Skin	☐	☐	☐
CONSTITUTIONAL			
Fever	☐	☐	☐
Weight Gain/Loss (Sudden)	☐	☐	☐
ENDOCRINE			
Thyroid Abnormalities	☐	☐	☐
EARS, NOSE, AND THROAT			
Allergies	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Mouth/Throat	☐	☐	☐
Hay Fever	☐	☐	☐
Runny Nose	☐	☐	☐
Sinus Congestion	☐	☐	☐

GASTROINTESTINAL (Stomach)	YES	NO	UNKNOWN
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Ulcers	☐	☐	☐
GENITOURINARY			
Chlamydia	☐	☐	☐
Gonorrhea	☐	☐	☐
Kidney Disease	☐	☐	☐
Syphilis	☐	☐	☐
INTEGUMENTARY (Skin)			
Eczema	☐	☐	☐
Psoriasis	☐	☐	☐
LYMPHATIC/HEMATOLOGIC			
AIDS	☐	☐	☐
Anemia	☐	☐	☐
Bleeding Disorder	☐	☐	☐
Hepatitis	☐	☐	☐
Herpes	☐	☐	☐
HIV Positive	☐	☐	☐
Liver Disease	☐	☐	☐
NEUROLOGIC			
Epilepsy	☐	☐	☐
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Seizures	☐	☐	☐
PSYCHIATRIC			
Depression	☐	☐	☐
High Anxiety	☐	☐	☐
REPRODUCTIVE			
Nursing Mother	☐	☐	☐
Pregnant	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Pneumonia	☐	☐	☐
Tuberculosis	☐	☐	☐
VASCULAR			
Diabetes	☐	☐	☐
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Stroke	☐	☐	☐

FOR DOCTOR”S USE:

Reviewed: ____/____/____ ______________ Reviewed: ____/____/____ ______________ Reviewed: ____/____/____ ______________

Reviewed: ____/____/____ ______________ Reviewed: ____/____/____ ______________ Reviewed: ____/____/____ ______________

Reviewed: ____/____/____ ______________ Reviewed: ____/____/____ ______________ Reviewed: ____/____/____ ______________