ERWIN EYE CLINIC

Date:_____

Patient Name:_____ Date of Birth_____ age _____

Address_____ SS#_____

_____ male ____ female_____

Home phone_____ cell phone_____ text? yes no

Email address:_____ Marital Status ☐ single ☐ married ☐ other

Occupation_____ Employer_____ Work #_____

Parent's name (if minor)_____

Spouse's name_____ D.O.B._____

Emergency contact _____phone_____

Persons that I give Erwin Eye Clinic/Southern Eye Associates permission to discuss and use the patient's protected health information including condition and treatment plan, test results, prescriptions.

Name relationship phone number

_____

_____

Insurance Co_____ ID #_____ Group _____

Secondary Insurance_____ ID#_____ Group _____

Medical Doctor_____ Pharmacy_____ ___ph#_____

Medical Allergies_____

List of medications_____

_____

_____

_____

ARE YOU A DIABETIC? YES NO INSULIN DEPENDANT? YES NO

I have received the Notice of Privacy Practices and Patients Rights of this practice. I acknowledge that all information on this form is accurate and up to date. It is customary to pay for professional services when rendered. If you do not have medical insurance the arrangements must be made in advance for payment. We accept assignment on Medicare, Medicaid and Arkansas Blue Cross and Blue Shield. Patients will be responsible for any Medicare or insurance deductible and their co-insurance amounts.I hereby authorize this office to furnish medical information to my insurance carriers, including Medicare, Medicaid, and Ar. BC/BS and assign to Erwin Eye Clinic all payments for services rendered.

Patient's Signature_____ ***Date*** _____

Physician's signature_____**Date**_____

AGREEMENT OF RESPONSIBILTY

I request that payment of authorized Medicare, Medicaid, or other insurance benefits be made on my behalf to **Erwin Eye Clinic** for any services furnished to me by a physician of the group. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents or other insurance any information needed to determine these benefits payable for related services. In Medicare assigned cases, the provider agrees to accept the change determination of the Medicare contractor, and I am responsible for all deductibles, co-insurance of any amount insurance does not pay, and for any non – covered services

RELEASE OF INFORMATION The Erwin Eye Clinic is authorized to furnish information from the Patient's medical record to any insurer, compensation carrier, or welfare agency that may be providing financial assistance for **Erwin Eye Clinic** care. The patient indemnifies the **Erwin Eye Clinic** and holds it harmless from any and all damage or prejudice which might result to the patient or his/her relatives or heirs from use or misuse by the insurance company of the information turned over to it by the **Erwin Eye Clinic** pursuant to the patient's written authorization.

I hereby authorize **Erwin Eye Clinic**, it's agents, affiliates and employees to have access to my medical records for the purpose of performing its billing and collection, administrative, financial, and business functions.

MEDIGAP OR OTHER SECONDARY INSURANCEI also request that the payment of authorized Medicare benefits or other secondary insurance be made either by me or on my behalf to **Erwin Eye Clinic**, or any physician of that group, for services provided to me by a physician of the group. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits payable for related services. I understand I am responsible for any deductible, co-pay, co-insurance and/or any non- covered procedures .This assignment shall remain in effect until revoked by me in writing. A photocopy of the assignment is considered as valid as the original. My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

Signature:_____

Date: _____

If the account is assigned to a collection company an additional fee of 50% the owed amount will be added to the balance.

_____ _____ _____

Patient Signature **Date** **Witness**

_____ _____ _____

Legal Guardian's or POA Relation to patient Policy Holder

MEDICAL HISTORY QUESTIONNAIRE

Name:_____

REVIEW OF SYSTEMS : Primary reason for today's (first) visit:_____

Do you presently have any problems in the following area? If "yes", give explanation.

	YES	NO	EXPLANATIONS
EYES			
Loss or blurred vision	[]	[]	_____
Loss of side vision, double vision	[]	[]	_____ _
Itching, burning or discharge	[]	[]	_____
Redness	[]	[]	_____
Gritty feeling, dryness or tearing	[]	[]	_____
Glare/light sensitivity, or halos	[]	[]	_____
Eye pain or soreness	[]	[]	_____
Infection of eye lashes or lids, styes	[]	[]	_____
Ears, nose, mouth, throat	[]	[]	_____
Cardiovascular,(heart,blood vessels)	[]	[]	_____ _
Respiratory (lungs, breathing)	[]	[]	_____ _
Gastrointestinal (stomach/intestines)	[]	[]	_____ _
Genitourinary (genitals,kidney,bladder)	[]	[]	_____ _
Musculoskeletal (muscles,joints)	[]	[]	_____
Integument (skin,breast)	[]	[]	_____ _
Neurological	[]	[]	_____ _
Psychiatric	[]	[]	_____
Endocrine (hormones, glands)	[]	[]	_____
Hematologic/Immunologic (blood)	[]	[]	_____ _
Seasonal allergies (hay fever, etc.)	[]	[]	_____ _

PAST HISTORY (EYE)	**YES**	**NO**
Eye drops currently in use:_____		
Allergies to eye drops	[]	[]
History of cataract, glaucoma	[]	[]
History of cross/lazy eye	[]	[]
Eye injury or other disease	[]	[]
Eye surgery	[]	[]

FAMILY HISTORY

OCCULAR	YES	NO	EXPLANATION/RELATIONSHIP
Blindness	[]	[]	_____
Cataract	[]	[]	_____
Glaucoma	[]	[]	_____
Macular degeneration	[]	[]	_____
Retinal detachment	[]	[]	_____

MEDICAL

Diabetes	[]	[]	_____
Arthritis, lupus, etc.	[]	[]	_____
Other (list)	[]	[]	_____

SOCIAL HISTORY

OCCULAR	YES	NO	EXPLANATION
Have you ever tried to wear contacts?	[]	[]	_____
Did you have problems w/th contacts?	[]	[]	_____

Vision causes problems with:

[] Driving []Night Vision []Reading []Sports/outdoor activities

GENERAL

Do you drink alcohol? [] []

Do you smoke? [] [] How much per day? ----------

Have you ever had a blood transfusion? [] []

Patient's signature:_____Date_____

HISTORY REVIEWED [] NO CHANGES [] ADDITIONS AS NOTED

Physician's signature:_____Date_____