Eyes On Albertville & Eyes On Guntersville

FAMILY VISION HEALTH CARE & DESIGNER EYE WEAR

Patient Information

Last Name: _____ First: _____ Middle: _____
Preferred name: _____ Date of Birth: _____/_____/_____ Sex: *M* / F
SSN _____-_____-_____ Driver's License #: _____ Marital Status: *S* / M / W / D
Employer & Occupation: _____ Student: grade ____ school _____
Preferred Language: _____ Ethnicity: *Hispanic/Latino* / **Not** *Hispanic/Latino*
Race: *American Indian or Alaskan Native* / *Asian* / *African American* / *Pacific Islander* / *Caucasian*

Address: _____
City/Zip: _____
Home Phone: _____
Cell Phone:_____
Email: _____
Emergency Contact: _____
Relationship: _____
Phone: _____

Primary Medical Insurance: _____
Policy #_____ Group #_____
Name of Insured: _____
DOB: _____/_____/_____
Vision Plan: _____
Policy #_____ Group #_____
Name of Insured: _____
DOB: ____/_____/_____

How did you hear about us? _____

Financial Information

Is the patient responsible for the bill? Yes / No If no, please complete the following information:
Guarantor: Last Name: _____ First Name: _____
Date of Birth:_____/_____/_____ Social Security #:_____
Address: _____
Home Phone: _____Work Phone: _____
Employer: _____Relationship: _____

Collection Policy

Our doctors participate in a variety of insurance plans. As a courtesy to our patients, we will be happy to file most claims. You will be expected to provide us with your insurance policy information before or during the time of your appointment. You will also be expected to pay your co-pay, deductible, and any non-covered service at each visit. For example, refractions, which are a necessary component of an eye exam, are not covered by Medicare. If your insurance requires a referral, it is your responsibility to contact your primary care physician and obtain the referral number and any other necessary information.

I authorize the release of any medical information necessary to process a claim on any insurance policy of which I have listed above or provided to Eyes on Albertville, LLC. I hereby assign to and authorize payment directly to Eyes on Albertville LLC for all benefits payable under such insurance policy. I realize that the insurance benefits may not pay all of the bill, and I agree to pay the difference or the entire bill if necessary. In the event of default in the payment of my charges, I agree to pay all cost of collection, including a reasonable attorney's fee, should the account be referred to an attorney for collection.
I have read the above policies and agree as indicated by my signature.

_____ _____

Patient or Responsible Party Signature Date

Patient Name:_____ **Date of Birth:**____/____/_____

Medical History Questionnaire

Last Medical Exam: ____/____/_____ Medical Doctor (name, location): _____
Last Eye Exam: ____/____/_____ Last Eye Care Provider: _____
Pharmacy (name, location): _____ _____

Past Eye History

Have you ever had any eye injuries? ☐**No** ☐**Yes**_____ Surgeries?☐**No** ☐**Yes**_____
List any eye drops you use: _____
Do you wear glasses? ☐**No** ☐**Yes** / How old is your present pair of lenses? _____
Do you wear contact lenses? ☐**No** ☐**Yes** / What brand or material? _____
Do you have or ever had any of the following eye conditions or diseases? Please check all that apply.
☐**Cataracts** ☐**Glaucoma** ☐**Macular Degeneration** ☐**Retinal Disease** ☐**Dry Eye** ☐**Lazy Eye**
☐**Loss of Vision** ☐**Double Vision** ☐ **Flashes/Floaters** ☐**Other**_____

Past Medical History

Do you have any medical conditions? Please check all that apply.
☐**Diabetes** (type:____) ☐**High Blood Pressure** ☐**Heart Disease** ☐**High Cholesterol** ☐**Stroke**
☐**Thyroid Disorder** ☐**Cancer** (type:_____) ☐ **Kidney Disease** ☐**Arthritis**
☐**Autoimmune Disease** (name:_____) ☐**Other**_____

List all medications:_____
_____
_____
_____
Allergies ☐**No** ☐**Yes** / List: _____
Major surgeries/ hospitalizations: _____
_____

Are you pregnant? ☐**No** ☐**Yes** / _____weeks Are you nursing ☐**No** ☐**Yes**
Current smoker? ☐**No** ☐**Yes**/ How Long? _____ Former smoker? ☐**No** ☐**Yes**/ Years Quit? _____
Have you ever been exposed to or infected with: ☐**Gonorrhea** ☐**Syphilis** ☐**HIV** ☐**Hepatitis**

Family History: (check all that apply to your blood relatives and indicate their relationship to you)

☐**Blindness**_____ ☐**Glaucoma**_____
☐**Macular Degeneration**_____ ☐**Retinal Disease/Detachment**_____
☐**Cataracts**_____ ☐**Lazy Eye**_____
☐**Diabetes**_____ ☐**Heart Disease**_____
☐ **Stroke**_____ ☐**High Blood Pressure**_____
☐**Arthritis**_____ ☐**Kidney Disease** _____
☐**Thyroid Disorder**_____ ☐**Autoimmune Disease**_____
☐**Other:**_____

Review of Systems

Do you currently have any problems in the following areas?

General		*Cardiovascular*		*Endocrine*	
Fatigue/Weakness	☐No ☐Yes	Heart attack	☐No ☐Yes	Thyroid (low)	☐No ☐Yes
Fever	☐No ☐Yes	Heart disease	☐No ☐Yes	Thyroid (high)	☐No ☐Yes
Weight gain/loss	☐No ☐Yes	Stroke	☐No ☐Yes	Diabetes	☐No ☐Yes
Jaw pain when chewing	☐No ☐Yes	High blood pressure	☐No ☐Yes	Pituitary disorder	☐No☐Yes
Scalp tenderness	☐No ☐Yes	Irregular heart beat	☐No ☐Yes	*Psychiatric*	
Skin		Vascular disease	☐No ☐Yes	Anxiety	☐No ☐Yes
Rashes/Sores	☐No ☐Yes	*Gastrointestinal*		Depression	☐No ☐Yes
Rosacea	☐No ☐Yes	Esophageal Reflux	☐No ☐Yes	Bipolar disorder	☐No ☐Yes
Hives/Eczema	☐No ☐Yes	Digestive Disorder	☐No ☐Yes	Schizophrenia	☐No ☐Yes
Neurological		Ulcer	☐No ☐Yes	Difficult sleep	☐No ☐Yes
Headaches/Migraines	☐No ☐Yes	Cirrhosis	☐No ☐Yes	*Immunological*	
Seizures	☐No ☐Yes	Hepatitis	☐No ☐Yes	Allergies	☐No ☐Yes
Multiple Sclerosis	☐No ☐Yes	*Genitourinary*		Hay Fever	☐No ☐Yes
Numbness	☐No ☐Yes	Kidney Stones	☐No ☐Yes	Lupus	☐No ☐Yes
Tremors	☐No ☐Yes	Urinary Disorder	☐No ☐Yes	Sarcoidosis	☐No ☐Yes
Eyes		History of STDs	☐No ☐Yes	Sjogren's	☐No ☐Yes
Other not listed above	☐No ☐Yes	*Musculoskeletal*		*Lymphatic/Hematologic*	
_____		Rheumatoid Arthritis	☐No ☐Yes	Anemia	☐No ☐Yes
Ear, Nose, Throat		Osteoarthritis	☐No ☐Yes	Bruise easily	☐No ☐Yes
Hard of hearing	☐No ☐Yes	Myasthenia Gravis	☐No ☐Yes	Aspirin Use	☐No ☐Yes
Ringing in ears	☐No ☐Yes	Fibromyalgia	☐No ☐Yes		
Dizziness/Vertigo	☐No ☐Yes	*Respiratory*		*Other*	
Sinus congestion/pressure	☐No ☐Yes	Asthma	☐No ☐Yes	Cancer	☐No ☐Yes
		Emphysema	☐No ☐Yes	_____	
		Sleep Apnea	☐No ☐Yes	_____	

Explanations:

_____ _____

Patient/ Guardian Signature Date

_____ _____

Print Name of Patient/Guardian Relation to Patient (if signed by Guardian)