VIDALIA EYECARE CENTER

PLEASE PRINT **Today's Date**_____

Patient's Name_____**Sex**___**Race**____**Birth Date**_____

Address_____

City/State_____**Zip**_____**Home PH#**_____**Work PH#**_____

SSN#_____**Employer**_____

Person Responsible for Charges_____

Address_____**PH#**_____

Insurance Information: (Please give Copy of Insurance to Receptionist)

Insurance Name_____**Policy#**_____

Group#_____ **Policy Holders Name**_____

Policy Holders Birth Date_____**Work PH#**_____**Home PH#**_____

Policy Holders Employer_____**Employer Address**_____

Primary Care Physician_____

Pharmacy/Pharmacies Used for Prescriptions_____

Were You Referred Here By Someone?_____**If YES, Whom?**_____
Has Anyone in Your Family Been Here Before?_____**If YES, Who?**_____

Are You Allergic to Any Medications?_____**If YES, List:**_____
_____

Reason For Today's Visit:_____
_____

(INSURANCE RELEASE INFORMATION)

I AUTHORIZE BAXLEY EYECARE CENTER TO RELEASE ANY NECESSARY MEDICAL INFORMATION TO MY INSURANCE CARRIER THAT MAYBE NEEDED TO PROCESS ANY DATES OF SERVICE.

SIGNATURE_____

ALL CHARGES, CO-PAYS AND DEDUCTIBILES ARE DUE AT THE TIME, THE SERVICES ARE RENDERRED, UNLESS OTHER ARRANGMENTS HAVE BEEN MADE

MEDICAL HISTORY QUESTIONNAIRE

Name_____Date_____

Date of Birth_____ Date of last Eye Exam_____

List any medications you currently take (Prescription and Over the Counter):_____
_____

Are you Allergic to any Medications? **(**Circle one) **YES or NO** If YES list the Medication:_____
_____

List all major illnesses: (glaucoma, diabetes, high blood pressure, heart attack, etc.) or Injuries (concussion etc.)
_____
_____

List any surgeries you have had: (cataract, tonsillectomy, appendectomy, etc.)_____
_____
_____

Do you ***currently*** have any problems in the following areas? If "YES" please provide information.

	YES	**NO**	**Explanation of Problem**
EYES (glaucoma,cataract,retinal disease,etc)			
Loss of vision			
Blurred Vision			
Fluctuating Vision			
Distorted Vision (halos)			
Loss of side Vision			
Double Vision			
Dryness			
Mucous Discharge			
Redness			
Sandy or Gritty Feeling			
Itching			
Burning			
Foreign Body Sensation			
Excess Tearing/Watering			
Glare/Light Sensitivity			
Eye Pain or Soreness			
Infection of Eye or Lid (Blepharitis, Sty)			
Tired Eyes			
Crossed Eyes, Lazy Eye			
Drooping Eyelid			
GENERAL/CONSTITUTIONAL			
Fever			
Weight Loss			
Other			
EARS,NOSE,THROAT (Sinus, Ear Infection,ChronicCough, Dry Mouth,etc)			

CARDIOVASCULAR (Heart, Vessels, etc.)			
RESPIRATORY (Asthma, Emphysema, etc.)			
GASTROINTESTIONAL (Stomach, Ulcers, Intestinal Diseases, etc)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, Warts, Skin Cancer, etc.)			
NEUROLOGICAL (Multiple Sclerosis, etc.)			
PSYCHIATRIC (Anxiety, Depression, Insomnia, etc.)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (Cholesterolemia, Anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, Lupus, Sjogrens, etc.)			

FAMILY HISTORY **M=mother F=father S=sibling GP=grandparent**

DISEASE	**YES**	**NO**	**RELATIONSHIP TO PATIENT**
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart Disease or High Blood Pressure			
Kidney Disease			
Lupus			
Stroke			
Thyroid Disease			
Other			

SOCIAL HISTORY

Current Occupation:_____
Education Level (High School, Vo-Tech, College Degree):_____
Martial Status (Married, Single, Divorced, Widowed):_____
Living Arrangements:_____

CIRCLE ONE

Do You Drive? YES NO
Do You Have Visual Difficulty When Driving? YES NO
Have You Tried To Wear Contact Lenses? YES NO
Do You Currently Contact Lenses? YES NO
If YES, How Long Have You Worn Contact Lenses?_____
Do You Currently Wear Glasses? YES NO
If YES, How Long Have You Had The Current Prescription?_____
Do You Drink Alcohol? YES NO If YES: occasional 1 per day 2-3 per day 4+ per day
Do You Smoke? YES NO If YES: occasional 1 per day 2-3 per day 4+ per day
Have You Had a Blood Transfusion? YES NO
History Reviewed: NO Changes ADDITIONS as noted Above.

Physician's Signature:_____

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

_____ _____
BENEFICIARY NAME (PRINT) **INSURANCE NUMBER**

1. **MEDICARE:** I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF TO **VIDALIA EYECARE CENTER** FOR SERVICES FURNISHED ME BY **VIDALIA EYECARE CENTER**. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE HEALTH CARE FINANCING ADMINSTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENTS 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, MY SIGNATURE AUTHORIZES RELEASING THE INFORMATION TO THE INSURER OR AGENCY SHOWN. **VIDALIA EYECARE CENTER** ACCEPTS THE CHARGE DETERMINATION OF MEDICARE CARRIER AS THE FULL CHARGE, AND I AM RESPONSIBLE ONLY FOR THE DEDUCTIBLE COINSURANCE AND NONCOVERED SERVICES. COINSURANCE AND DEDUCTIBLES ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARRIER._____INTIAL

2. **MEDIGAP:** I UNDERSTAND THAT IF A MEDIGAP POLICY OR OTHER HEALTH INSURANCE IS INDICATED IN ITEM 9 OF THE HCFA 1500 FORM OR ELSEWHERE ON OTHER APPROVED CLAIM FORMS, MY SIGNATURE AUTHORIZES RELEASE OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN. I REQUEST THAT PAYMENT OF AUTHORIZED SECONDARY INSURANCE BENEFITS BE MADE ON MY BEHALF TO **VIDALIA EYECARE CENTER**, IF POSSIBLE OR OTHERWISE TO ME._____INTIAL

3. **RELEASE OF INFORMATION: VIDALIA EYECARE CENTER** MAY DISCLOSE ALL OR PART OF MY MEDICAL RECORD AND/OR FINANCIAL LEDGER, INCLUDING INFORMATION REGUARDING ALCOHOL OR DRUG ABUSE, PSYCHATIC ILLNESS, COMMUNICABLE DISEASE, OR HIV, TO ANY PERSON OR CORPORATION (1) WHICH IS OR MAY BE LIABLE OR UNDER CONTRACT TO **VIDALIA EYECARE CENTER** FOR REIMBURSEMENT FOR SERVICES RENEDERED, AND (2) ANY HEALTH CARE PROVIDER FOR CONTINUED PATIENT CARE. **VIDALIA EYECARE CENTER** MAY ALSO DISCLOSE ON AN ANONYMOUS BASIS ANY INFORMATION CONCERNING MY CASE, WHICH IS NECESSARY OR APPROPRIATE FOR THE ADVANCEMENT OF MEDICAL SCIENCE, MEDICAL EDUCATION, MEDICAL RESEARCH, FOR THE COLLECTION OF STATISTICAL DATA, OR PURSUANT TO STATE OR FEDERAL LAW, STATURE, OR REGULATION. A COPY OF THIS AUTHORIZATION MAYBE USED IN PLACE OF THE ORGINAL._____INTIAL

4. **OTHER INSURANCE:** I UNDERSTAND THAT **VIDALIA EYECARE CENTER** MAINTAINS A LIST OF HEALTH CARE SERVICE PLANS WITH WHICH IT CONTRACTS. A LIST OF SUCH PLANS IS AVAILABLE FROM THE BUSINESS OFFICE, AND THAT **VIDALIA EYECARE CENTER** HAS NO CONTRACT, EXPRESSED OR IMPLIED, WITH ANY PLAN THAT DOES NOT APPEAR ON THE LIST. THE UNDERSIGNED AGREES THAT I AM INDIVIDUALLY OBLIGATED TO PAY THE FULL CHARGES OF ALL SERVICES RENEDERED TO ME BY **VIDALIA EYECARE CENTER**. IF I BELONG TO A PLAN THAT DOES NOT APPEAR ON THE ABOVE MENTIONED LIST._____INTIAL

5. **NON-COVERED SERVICES:** I UNDERSTAND THAT **VIDALIA EYECARE CENTER** CONTRACTS WITH HEALTH CARE SERVICES PLANS (I.E. HMOS, PPOS) STATE ITEMS AND SERVICES WHICH ARE "COVERED" BY THE HEALTH CARE

SERVICES PLANS, ACCORDINGLY, THE UNDERSIGNED ACCEPTS FULL FINANCIAL RESPONSIBILITY FOR ALL ITEMS OR SERVICES, WHICH ARE DETERMINED BY THE HEALTH CARE SERVICES PLANS NOT COVERED. EXAMPLES OF NON-COVERED SERVICES INCLUDE, BUT ARE NOT LIMITED TO, SERVICES NOT SPECIFIED AS BEING COVERED IN THE PATIENTS CONTRACT WITH A HEALTH CARE SERVICES PLAN OR IN THE BENEFIT SUMMARY OF THE HEALTH CARE SERVICES PLAN FURNISHES TO THE PATIENT: AND TREATMENT OR TESTS NOT AUTHORIZED BY THE HEALTH CARE SERVICES PLAN. THE UNDERSIGNED AGREES TO COOPERATE WITH **VIDALIA EYECARE CENTER** TO OBTAIN NECESSARY CARE SERVICES PLAN AUTHORIZATIONS._____INTIAL

6. **FINANCIAL AGREEMENT:** I AGREE THAT IN RETURN FOR THE SERVICES PROVIDED TO THE PATIENT BY **VIDALIA EYECARE CENTER**, I WILL PAY MY ACCOUNT AT THE TIME SERVICE IS RENDERED OR WILL MAKE FINANCIAL ARRANGEMENTS SATISFACTORY TO **VIDALIA EYECARE CENTER** FOR PAYMENT. IF AN ACCOUNT IS SENT TO AN ATTORNEY FOR COLLECTION, I AGREE TO PAY COLLECTION EXPENSES AND REASONABLE ATTORNEY'S FEES AS ESTABLISHED BY THE COURT AND NOT BY A JURY IN ANY COURT ACTION. I UNDERSTAND AND AGREE THAT IF MY ACCOUNT IS DELIQUENT, I MAYBE CHARGED INTEREST AT THE LEGAL RATE. ANY BENEFITS OF ANY TYPE UNDER ANY POLICY OF INSURANCE INSURING THE PATIENT OR ANY OTHER PARTY LIABLE TO THE PATIENT, IS HEREBY ASSIGNED TO **VIDALIA EYECARE CENTER**. IF COPAYMENTS AND/OR DEDUCTIBLES ARE DESIGNATED BY MY INSURANCE COMPANY OR HEALTH PLAN, I AGREE TO PAY THEM TO **VIDALIA EYECARE CENTER**. HOWEVER IT IS UNDERSTOOD THAT THE UNDERSIGNED AND/OR THE PATIENT ARE PRIMARILY RESPONSIBLE FOR THE PAYMENT OF MY BILL._____INTIAL

SIGNATURE:_____ **DATE**_____