DO GOOD EYE CARE

Patient Information:

Name: _____ Gender: _____ DOB: _____

(First) (MI) (Last)

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Social Security #: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer/School: _____ Occupation/Grade: _____

Spouse/Parent's Name: _____ Who may we thank for referring you? _____

Insurance Information:

Name of Person Insured: _____ Relationship to Patient: _____

DOB of Insured: _____ Social Security # of Insured: _____ Group #: _____

Employer: _____ Name of Insurance:_____ Contract/Member ID #: _____

Reason for today's exam: _____

Date of Last Eye Exam: _____ Name of Eye Doctor/Clinic: _____

Do you wear glasses? _____ Contacts? _____ Brand _____ Are you interested in contacts? _____

What hobbies/sports do you participate in? _____

Date of last physical exam? _____Name of Primary Physician: _____Phone:_____

Please list all medications you are currently taking (Prescription, Over-the-counter, or Vitamins):

_____

_____

Please list any drug allergies: _____

Do **YOU** or anyone in your immediate family **(mother (M), father (F), siblings (B/S), children (C)** have a history of the following?

_____Glaucoma	_____Thyroid Disease	_____Lung Disease
_____Retinal Detachment	_____High Blood Pressure	_____Heart Disease/Stroke
_____Blindness	_____Cataracts	_____Cancer
_____Turned or Lazy Eye	_____Macular Degeneration	_____Diabetes: Type____

_____Other Eye Disease/Condition

Authorization:

I certify that I have completed the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release information (including diagnosis and treatment) rendered to me or my child to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of the exam.

_____ _____

Signature of Patient (or parent/guardian in a minor) Date

310 18th Street N, Ste 100 I Birmingham, AL 35203
(205) 774-1010 I Tiffany Luke, OD
birminghamoptometrist.com

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Disclosure of Protected Health Information (PHI) and Privacy Practices Acknowledgement

Name of Patient: _____

Date of Birth: _____ Social Security Number: _____

Please list the names any persons/organizations you will allow us to release eye examination information (including all prescriptions) to, if necessary. Most commonly listed entities include parents, spouse, children, or other health care facilities outside the scope of optometric/medical practices.

_____
_____
_____
_____

We may use/disclose your PHI for the purposes of treatment, payment, and health care operations.

You may update your authorization at any time by adding or deleting names already listed.

I understand that, by signing this form, I am confirming my authorization for the use/disclosure of the PHI described in this form with the people and/or organizations named in this form.

I also acknowledge that I have received the Notice of Privacy Practices and have been provided with an opportunity to review it.

_____ _____

Signature of Patient or Parent/Guardian Date

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Social History:

Do you drink alcohol? __No __Occasionally ___1/day ___2-3+/day
Do you smoke? __No __Occasionally __1/2 pack/day ___ 1 pack/day or more

Review of Systems:

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

Allergic/Immunologic
____Drug Allergy
____Environmental Allergy
____Rheumatoid Arthritis
____Lupus
____Other

Eyes
___Glaucoma
___Cataract
___Macular Degeneration
___Surgery
___Inflammatory Disorders
___Blurred Vision
___Double Vision
___Other _____

Musculoskeletal
___Fibromyalgia
___Muscular Dystrophy
___Osteoarthritis
___Ankylosing Spondylitis
___Other _____

Cardiovascular
___Heart Disease
___Hypertension
___Stroke
___Vascular Disease
___Other_____

Gastrointestinal
___Crohns Disease
___Colitis
___Ulcer
___Digestive
___Other_____

Neurological
___Multiple Sclerosis
___Epilepsy
___Alzheimer Disease
___Parkinson Disease
___Cerebrovascular
___Other

Constitutional
___Developmental Disability
___Weight Loss
___Fever
___Fatigue
___Trauma
___Other_____

Genitourinary
___STD
___Viral Herpetic
___Chlamydia
___HIV
___Other_____

Psychiatric
___Depression
___Panic Disorder
___Schizophrenia
___Other_____

Ear, Nose, Throat
___Upper Respiratory Infection
___Earache
___Runny nose
___Sore throat
___Ringing (tinitis)
___Other_____

Hematological/Lymphatic
___Anemia
___Large volume blood loss
___Leukemia
___Other_____

Respiratory
___Cigarette Smoker
___Asthma
___Bronchitis
___Emphysema
___Other_____

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Endocrine
___Type 1 Diabetes Mellitus
___Type 2 Diabetes Mellitus
___Thyroid
___Hormonal Dysfunction
___Other_____

Integumentary
___Eczema
___Rosacea
___Psoriasis
___Other_____

Signature:_____ Date:_____

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