



WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to help you.

PATIENT INFORMATION

<p>Date _____</p> <p>Patient _____</p> <p>Address _____</p> <p>_____</p> <p>_____</p> <p>City _____ State _____ Zip _____</p> <p>Sex: M F Birthdate _____</p> <p>Patient SS# _____</p> <p>Occupation _____</p> <p>Employer _____</p> <p>Are any other members of your family patients here? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you work at a computer? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, how many hours at the computer per day? _____</p> <p>Spouse's Name _____</p> <p>Are you interested in trying Contact Lenses today?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>Are you interested in Laser surgery to correct your vision problem?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>Are you interested in a non-surgical correction for your vision problem?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>Who is responsible for this account? _____</p> <p>Relationship to Patient _____</p> <p style="text-align: center;">Insurance Information</p> <p>Vision Insurance _____</p> <p>Member ID _____</p> <p>Medical Insurance _____</p> <p>Member ID _____</p> <p style="text-align: center;">Policy Holder Information</p> <p>Name _____</p> <p>Date of Birth _____ SS # _____</p> <p>Relationship to patient _____</p> <p style="text-align: center;">Referral Information</p> <p>How did you find out about our office?</p> <p><input type="checkbox"/> Mailer (specific) _____</p> <p><input type="checkbox"/> Drove by _____</p> <p><input type="checkbox"/> Insurance (specific) _____</p> <p><input type="checkbox"/> Internet/Website _____</p> <p><input type="checkbox"/> Friend/Patient (specific) _____</p> <p><input type="checkbox"/> Doctor (specific) _____</p>
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PHONE NUMBERS & EMAIL

Home _____ Work _____ Ext _____ Cell _____

Best way to contact you: Home Work Cell Email Email Address _____

IN CASE OF EMERGENCY NOTIFY:

Name _____ Home Phone _____ Work _____

EYE HEALTH HISTORY

<p>Date of last eye exam? _____</p> <p>Name of Dr. _____</p> <p>Do you wear glasses? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> All the time <input type="checkbox"/> Occasionally</p> <p><input type="checkbox"/> Reading <input type="checkbox"/> Driving <input type="checkbox"/> TV</p> <p>Do you wear contacts? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Type: <input type="checkbox"/> Soft <input type="checkbox"/> RGP <input type="checkbox"/> Hard</p> <p>Do you sleep in lenses? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>How often do you replace your lenses? _____</p>	<p>Place a mark on "Yes" or "No" to indicate if you have any of the following:</p> <table style="width:100%; border: none;"> <tr> <td>Bloodshot Eyes</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td> <td>Eye Strain</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td> </tr> <tr> <td>Blurred Vision-Distance</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td> <td>Floaters or Spots</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td> </tr> <tr> <td>Blurred Vision - Near</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td> <td>Flashes of Light</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td> </tr> <tr> <td>Burning Eyes</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td> <td>Headaches</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td> </tr> <tr> <td>Crossed Eyes</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td> <td>Itching Eyes</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td> </tr> <tr> <td>Discharge from eyes</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td> <td>Light Sensitive</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td> </tr> <tr> <td>Double Vision</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td> <td>Migraine Headache</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td> </tr> <tr> <td>Dry Eyes</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td> <td>Night Vision Poor</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td> </tr> <tr> <td>Eye Infection</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td> <td>Watering Eyes</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td> </tr> <tr> <td>Eye Injury</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td> <td>Twitching Eyelid</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td> </tr> <tr> <td>Dizzy Spells</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td> <td></td><td></td><td></td> </tr> </table>	Bloodshot Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye Strain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blurred Vision-Distance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Floaters or Spots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blurred Vision - Near	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Flashes of Light	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Burning Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Crossed Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Itching Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Discharge from eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Light Sensitive	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Double Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine Headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dry Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Night Vision Poor	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye Infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Watering Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Twitching Eyelid	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dizzy Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
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MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself		Family Member		Yourself		Family Member
AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Skin Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Thyroid Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis (Type____)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Eye Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Lazy Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Migraine Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Poor Color Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					Retinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other Medical or Eye Conditions: _____

Are You Pregnant? Yes No Do you use tobacco products? Yes No Do you use alcoholic beverages? Yes No

MEDICATIONS

List medications you are currently taking, including eye drops.

ALLERGIES

List any allergies to medications or other substances.

Signature _____

Date _____

Signature _____

Date _____

Signature _____

Date _____

Signature _____

Date _____

Signature _____

Date _____

Signature _____

Date _____

Patient Consent (HIPAA)

Payne & Payne, PC d.b.a. Alpharetta Eye Care & South Forsyth Eye Care
4330 Johns Creek Pkwy Ste 300
Suwanee, GA 30024

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

By signing this document, I have been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*. The *Notice of Privacy Practices* contains a more complete description of the uses and disclosures of my health information.

I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

Patient Name: _____ Guardian Name _____ Relationship To Patient _____

Signature: _____ Date: _____



Payment Policies & Procedures

(Please initial box and sign/date bottom)

- As a courtesy to our patients we will be happy to file your insurance for you. In the event that your insurance company does not pay for your bill, you acknowledge that you are ultimately responsible for the payment of all usual and customary fees. There are many different insurance plans available and all plans vary based on premiums, employers, etc. Although we have a broad knowledge on *most* insurance plans, it is ultimately your responsibility to know your individual plan and what it covers before your visit.

- Accounts 90 days old are subject to collection fees.

- There will be a \$25.00 service charge on all returned checks.

- All co pays and material costs not covered by your insurance are due at the date of service.

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to rendering care in this practice, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am 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 this signature on all insurance submissions.

Responsible Party Signature

Date



Dilation, Contact Lens Fees, Refraction

Patient Acknowledgement Regarding Dilation

During the course of your eye examination, it may be necessary to dilate your pupils. Dilation results in light sensitivity and often an inability to see at close range. These side effects usually last between 3 to 5 hours. If you do not have sunglasses of your own, our office will provide you with disposable sunglasses to help with the light sensitivity.

Patient Acknowledgement Regarding Contact Lens Evaluation Fee

Contact lens patients require additional testing and monitoring over and above what is done in a routine eye examination. This monitoring includes:

- a microscopic assessment of the contact lens on the eye to check the appropriateness of the lens fit,
- a microscopic examination of the cornea to inspect for adverse effects from contact lens wear such as oxygen deprivation
- a contact lens refraction to determine the correct contact lens prescription power
- a review of new lens designs and materials that may improve comfort and health of your eyes

There is an additional fee for this service (over and above the fee for a routine eye exam), which varies depending on a number of factors including the complexity of the prescription and the need for follow-up visits. Most vision plans do not cover this additional professional fee. Payment of the contact lens evaluation must be paid in full before contact lenses can be dispensed.

Patient Acknowledgement Regarding Refraction Fee

A "refraction" includes the testing to determine a person's need for glasses. This test is not covered by Medicare or most **medical insurance plans**. However, it is covered by **vision plans**.

If your diagnosis is medical in nature (such as cataract, dry eye, glaucoma, etc), then your exam could be billed to your medical insurance. If you would also like to have your vision prescription checked and updated, a refraction must be performed. The fee for this service is an additional \$25 and is collected at the time of service. We will not file the charge for a refraction with a medical insurance plan unless we know that the plan covers a refraction. Should your plan pay us for the refraction, we will reimburse you accordingly.

I have read and understand the above information. I accept full financial responsibility for the cost of refraction and/or contact lens evaluation **if provided** and if not covered by my insurance. I understand that any co-payment or deductible would be separate from and not included in either the refraction or contact lens fee.

Patient's Name

Date

Signature of Patient or Parent/Guardian