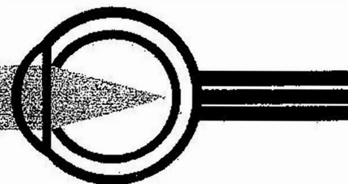
EAST ALABAMA EYE CLINIC



Diplomates American Board of Ophthalmology
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Thank you for choosing EAST ALABAMA EYE CLINIC for your eye care needs.

Attached are New Patient forms. Please fill them out and bring them with you when you come for your appointment.

Please bring all of the following in addition to the forms:

- **A list of all medications you are currently taking, which includes: the name, strength, frequency/dosage and route taken (oral, etc).**
- **Insurance cards**
- **A picture I.D.**
- **Co-pay (Specialist)**
- **Refraction fee of $45.00, if applicable (Vision/glasses prescription non-covered by most insurances)**

If you have any questions or concerns regarding your visit, please feel free to contact our office at (256) 237-0371. We "welcome" all comments in order to serve you better.

Thank you,

Scheduling Department

EAST ALABAMA EYE CLINIC

East Alabama Eye Clinic

Date: _______________ Account # ______________

Patient Name: ____ Circle: Male / Female

Preferred Language:___________________ Marital Status: _____________________ Race: __________________

Address: ___________________________________City: _________________State: ________ Zip: _________

Date of Birth: ______________________ Home Phone: _____________________ Cell: ___________________

Social Security # ________-______-_________ Driver's Licenses # __________________ State issued: _______

Place of Employment: ____ Work Phone: _______________

Spouse's Name: ______________________Place of Employment: __________________Work #:____________

Emergency Contact (not living in same household): ____

Relationship to Patient: _______________________________Phone #: ________________________________

Are you currently being followed by Hospice Care? YES or NO

Will this visit be Self-Pay / No Insurance? YES or NO

Primary Care Doctor: ____

IF PATIENT IS A MINOR

Father: ________________________________ DOB: __________________Home Phone:_________________

Place of Employment: ____Work Phone: _________________

Mother: _______________________________ DOB: __________________Home Phone:_________________

Place of Employment: ____Work Phone: _________________

INSURANCE INFORMATION

Primary Insurance:_________________________ Card Holder's Name:________________________________

Policy Number:____________________________ Group Number: _________________DOB: ______________

Secondary Insurance:_______________________ Card Holder's Name: _______________________________

Policy Number:____________________________ Group Number: _________________DOB: ______________

Tertiary Insurance: _________________________ Card Holder's Name:________________________________

Policy Number:____________________________ Group Number: _________________DOB: ______________

Amount of Insurance Co-Pay for Specialist $ _____________________

Turn over to complete form

Authorization

I authorize East Alabama Eye Clinic, PC and medical staff members to discuss my medical history, diagnosis, treatment and prognosis with those listed by name below. I understand that this may also include billing questions. I also understand that by leaving all spaces blank, I am indicating my choice to be “No information” patient, and I do not want any information released to anyone else.

List Name and relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, sibling, caretaker, and friend).

Name of Person Authorized:	**Relationship:**
____	__________________________________
____	__________________________________
____	__________________________________
____	__________________________________

I authorize East Alabama Eye Clinic to apply for benefits for services rendered to myself or dependent child and may release medical records and/or other information and records required by my insurance company including my employer and /or workman’s compensation, the center for Medicare and Medicaid services and Medigap plans needed to determine benefits and to process insurance claims. I irrevocable authorize all such insurance payments made to East Alabama Eye Clinic.

I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records.

I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) to read and understand and consent to East Alabama Eye Clinic’s use and disclosure of protected health information about myself or my minor child for treatment, payment and health care operations. I consent to the use or disclosure of my protected health information for purpose of diagnosing or providing treatment to myself or my child.

I have read East Alabama Eye Clinic’s “Financial and Registration Agreement” and agree that I am legally obligated and do hereby guarantee payment for all charges incurred by myself or dependents. Until my account or the account of my dependent is finally settled, I give my direct consent to receive communications regarding my account from any services and collectors of my account, though various means such as cell phone, landline, text number, auto dialer systems, voicemail messages, email and other forms of communications. I waive any and all claims of exemptions as to personal property under any applicable law, including, reasonable attorney’s fees, in the event all or any portion of the bill is unpaid and is referred to an attorney for collection.

I certify that the information I have reported with regard to my insurance coverage is correct. This certification will also apply to applications for benefits under Tile XVII of the Social Security Act and/or other governmental agency, if applicable. I also certify that I have read the forgoing and understand and fully accept the terms therein.

Signature____ Date_________________________________

Print Name and Relationship to Patient ____

Medical History Questionnaire

Today's Date ______/_______/________

Name: ____ Birth Date: ______/_______/_________

Ocular / Medical History

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair of lenses? ________________

Do you wear contact lenses? ☐ No ☐ Yes If yes, what type? ☐ RGP ☐ Soft

Do you sleep in them? ☐ No ☐ Yes

How often do you replace them?________________________ Are they comfortable? ☐ No ☐ Yes

Have you been diagnosed with any of the following ocular problems? Check box for "Yes"

☐ Cataracts	☐ Glaucoma	☐ Retinal Detachment
☐ Crossed Eyes	☐ Lazy Eye	☐ Drooping Eye lid
☐ Eye Injury	☐ Macular Degeneration	☐ Other: ___________________

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

	RELATION TO YOU		RELATION TO YOU
☐ Blindness	___________________	☐ Cancer	___________________
☐ Cataract	___________________	☐ Diabetes	___________________
☐ Crossed Eyes	___________________	☐ Heart Disease	___________________
☐ Glaucoma	___________________	☐ High Blood Pressure	___________________
☐ Macular Degeneration	___________________	☐ Kidney Disease	___________________
☐ Retinal Detachment	___________________	☐ Lupus	___________________
☐ Arthritis	___________________	☐ Thyroid Disease	___________________

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with doctor if you prefer. Please check the following box if you wish to discuss Social History with your doctor. ☐ *Yes*

Do you drive? ☐ No ☐ Yes If yes, describe any visual difficultly while driving: ________________________________

Do you use tobacco products? ☐ No ☐ Yes If yes, list type/ amount /how long: ______________________________

Do you drink alcohol? ☐ No ☐ Yes If yes, list type/ amount/ how long:____________________________________

Do you use illegal drugs? ☐ No ☐ Yes If yes, list type/ amount/ how long:___________________________________

Indicate by checking the box if you have been infected with or exposed to:

☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

**** Turn over to complete form ****

Review of Systems

Please check the box beside any problem you currently have or have had in the past.

ALLERGIC / HAY FEVER

- ☐ Allergy / Hay fever
- ☐ All Normal

CARDIOVASCULAR / CARDIAC

- ☐ Arteriosclerosis
- ☐ All Normal

CONSTITUTIONAL

- ☐ Fever
- ☐ All Normal
- ☐ Weight Loss / Gain

EARS, NOSE, MOUTH, THROAT

- ☐ Sinus Congestion
- ☐ All Normal
- ☐ Dry Throat / Mouth

ENDOCRINE

- ☐ Diabetes
- ☐ All Normal
- ☐ Thyroid Disease
- ☐ Chronic Fatigue

GASTROINTESTINAL

- ☐ Diarrhea
- ☐ All Normal
- ☐ Ulcers
- ☐ Reflux
- ☐ Constipation

GENITOURINARY

- ☐ Kidney Disease
- ☐ All Normal
- ☐ Ovarian / Uterine Cancer
- ☐ Prostate Cancer

HEMATOLOGIC / LYMPHATIC

- ☐ Anemia
- ☐ All Normal
- ☐ Bleeding Problems
- ☐ Breast Cancer

INTEGUMENTARY (SKIN)

- ☐ Cancer
- ☐ All Normal
- ☐ Rashes
- ☐ Easing Bruising

MUSCULOSKELTAL

- ☐ Rheumatoid Arthritis
- ☐ All Normal
- ☐ Muscle Pain
- ☐ Joint Pain

NEUROLOGICAL

- ☐ Headaches
- ☐ All Normal
- ☐ Dizziness
- ☐ Seizures
- ☐ Stroke

PSYCHIATRIC

- ☐ Anxiety
- ☐ All Normal
- ☐ Depression
- ☐ Memory Loss
- ☐ Hallucinations

RESPIRATORY

- ☐ Asthmas
- ☐ All Normal
- ☐ Bronchitis
- ☐ Chronic Cough
- ☐ Emphysema

If you checked any of the above boxes or have a condition not listed, please explain further:___________________________

____

Are you pregnant and/ or nursing? ☐ No ☐ Yes

Medications

LIST ANY DRUG ALLERGIES: ____

List ALL Prescriptions and Over the Counter Medications you are taking (including Eye Drops and Vitamins):

Name of Medication	Dosage	Taken how often? PRN= when needed	Route	Reason for taking

List all Eye Surgeries and Laser Eye Surgeries:

____
____
____
____

List all OTHER surgeries you have had:

____
____
____
____

NEW PATIENTS MUST PRESENT A PICTURE I.D. WHEN CHECKING-IN FOR THEIR FIRST APPOINTMENT.

THIS IS FOR IDENTIFICATION AND/OR INSURANCE PURPOSES. A NEW PATIENT WITHOUT A **PICTURE I.D. WILL NOT BE SEEN BY THE PHYSICIAN.**

ACCEPTABLE IDENTIFICATION:

A CURRENT DRIVERS LICENSE

A CURRENT STATE OF ALABAMA PICTURE I.D.

A CURRENT STUDENT PICTURE I.D.

A CURRENT WORK PICTURE I.D.

A NEW PATIENT WITHOUT A PICTURE I.D. WILL NOT BE SEEN BY THE PHYSICIAN. YOUR APPOINTMENT WILL BE RESCHEDULED FOR A TIME WHEN AN ACCEPTABLE PICTURE I.D. CAN BE PRESENTED.

ALSO: IF THE NEW PT IS UNDER THE AGE OF 18 YEARS OLD: THE PT **MUST HAVE A PARENT OR GUARDIAN** ACCOMPANY THEM TO THEIR **FIRST** APPOINTMENT. THE PARENT MUST SIGN AND/OR VERIFY THE SIGNING OF THE GUARANTOR FORM. AFTER THIS INITIAL APPOINTMENT, IF 14 YEARS OLD OR OLDER, THE PT WILL BE ALLOWED TO ATTEND APPOINTMENTS ON THEIR OWN, WITHOUT A PARENT OR GUARDIAN PRESENT.