

Today's Date _____

PATIENT INFORMATION

Last _____

First _____ MI _____

Date of Birth _____ Age _____

Sex M F SSN # _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Daytime Phone _____ Work Cell

Email _____

Employer or School _____

Occupation or Grade _____

Spouse or Parent's Name _____

What is the primary purpose of this visit?

Any problems with your current contacts or glasses?

Names of family members who are currently patients:

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?

If not referred, how did you choose our office?

- Doctor's Referral Insurance List
 Saw Sign/Building Yellow Pages
 Internet website _____
 Other _____

The mission of Oak Mountain Eye Care, P.C. is to:

- *Provide the highest quality of health care in both services and products.*
- *Inspire confidence through patient education.*
- *Promote a lifetime of visual excellence with a caring and dedicated team of staff.*

INSURANCE INFORMATION

Please note that insurance does NOT cover the Contact Lens Evaluation and Follow-up.

Vision Insurance _____

Member Name _____

ID # _____ Group # _____

Birth Date _____ SSN _____

Primary Medical Insurance _____

Member Name _____

ID # _____ Group # _____

Birth Date _____ SSN _____

Secondary Medical Insurance _____

Member Name _____

ID # _____ Group # _____

Birth Date _____ SSN _____

How will you settle your account today?

- Cash Check Debit / Credit / Flex Card

LIFESTYLE QUESTIONS

Do you ... (check box if your answer is yes)

- ...want to update your glasses?
 ...need more contact lens?
 ...wear glasses? What do you like/dislike about your current eyewear? _____
 ...have prescription sunglasses? ...polarized?
 ...work at a computer? _____ hrs/day
 ...think you might benefit from thinner, lighter lenses?
 ...spend time outdoors? _____ hrs/week
 ...prefer not to wear your glasses at times?
 ...want information on laser vision correction surgery?
 ...have more than one pair of current Rx eyewear?
 ...have school-age children?
 ...have family members in need of eye care?
 ...experience problems with glare from
 reading computer night driving/headlights

My hobbies include:

- ...fishing / water sports ...golf / tennis
 ...softball / baseball ...football
 ...spectator sports ...computer
 ...reading ...other _____

The information in this confidential case history form is critical to the evaluation of your vision and health.

PATIENT MEDICAL HISTORY

Name of Family Physician _____
 Date of Last Physical Check-up _____

CURRENT MEDICATIONS (Rx or over-the-counter)

(List name of medications including eye drops, vitamins, & birth control pills) _____

Allergies to medications? Yes No
 If so, what medications? _____

Have you had any **EYE** surgeries? Yes No
 If yes, please list type and date _____

Do you use cigarettes / tobacco, alcohol or other substances? Yes No

Have you ever been diagnosed with or treated for the following health problems?

- | | | |
|--|------------------------------|-----------------------------|
| Allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood / Lymph | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bronchitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer (type: _____) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Digestive | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ears / nose / throat | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Endocrine | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Eczema / Rashes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fatigue | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fevers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Genitourinary | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Skin | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Muscle / Bone | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Neurological | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Physiological | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Respiratory | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sinus | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Throat Infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Thyroid | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Unusual weight losses / gains (in past 6 months) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

PATIENT EYE HISTORY

Date of Last Eye Exam _____
 By Whom? _____

Have you ever tried contact lenses? Yes No

Do you currently wear contact lenses? Yes No
 What kind? _____
 Solutions used _____

Are you satisfied with the vision and comfort of your contact lenses? Yes No

Would you prefer clear contact lenses or colored contact lenses? Clear Colored

How often do you dispose of your contact lenses:
 Daily Every 2 weeks Monthly
 Other _____

Have you ever experience, been diagnosed or treated for any of the following eye problems:

- | | |
|--|---|
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Corneal abrasions |
| <input type="checkbox"/> Crossed eyes / eye turn | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Eye infections | <input type="checkbox"/> Eye injury |
| <input type="checkbox"/> Flash of light | <input type="checkbox"/> Floaters /spots |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Grittiness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Iritis / uveitis |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Lazy eye |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Occasional dryness |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Sunlight sensitivity |

FAMILY MEDICAL / EYE HISTORY

Is there a **family** medical history of the following:

- | | |
|---------------------|--------------------------------|
| | Relationship |
| Diabetes | <input type="checkbox"/> _____ |
| Heart Disease | <input type="checkbox"/> _____ |
| Glaucoma | <input type="checkbox"/> _____ |
| Lazy Eye | <input type="checkbox"/> _____ |
| Macular Degenration | <input type="checkbox"/> _____ |
| Retinal Problems | <input type="checkbox"/> _____ |
| Other | <input type="checkbox"/> _____ |

Signature

Date

Reviewed by Doctor

OAK MOUNTAIN EYE CARE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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.**

I have received, read and understand your **Notice of Privacy Practices** containing 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 to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

DATE: _____ INITIALS: _____ REASON: _____

Oak Mountain Eye Care, PC Insurance Policies

- ▶ We will gladly file your insurance; however, you will be responsible for any charges your insurance company does not pay.
- ▶ If your insurance company does not pay within 45 days of the date the claim was submitted, you will be billed for the balance. If your insurance company pays after this date, we will reimburse you.
- ▶ Please be aware that many insurance plans require that you see an “in-network” provider.
- ▶ Many plans also have restrictions on how often they will pay, i.e. one exam 12 months from the last date of service.
- ▶ Please also be aware that insurance benefits are sometimes misquoted by customer service representatives, and we can only go by the information we are given.
- ▶ **We will verify your insurance coverage whenever possible; however, you are ultimately responsible for knowing your insurance coverage and eligibility.**
- ▶ We are required to accept certain allowances for services with the insurance companies with which we are contracted; however, we are not required to accept the allowances of other insurance companies with which we are not contracted. You will be responsible for paying the amount the insurance company does not pay.

Thank you.

I have read the above insurance policies of Oak Mountain Eye Care, PC, and I agree to pay any charges that my insurance company does not pay. I understand that some services may not be covered as dictated by my insurance company. If my insurance company denies the claim as a non-covered service, I understand that I will be responsible for paying the balance. If my account becomes delinquent, I agree to pay all collection costs, including any attorney fees.

Patient or Guardian's Signature

Date

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Oak Mountain Eye Care, PC on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage, my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Print Name

Signature

Date