

**Southern Eye Center Welcomes You to Our Office**

**The doctors have asked that we get this information to help treat you and to help file insurance claims.**

**Please write clearly in ink.**

**Acct: # \_\_\_\_\_**

**Patient Information**

Patient's Name: \_\_\_\_\_ Social Security # \_\_\_\_\_  
First Middle Initial Last Spouse's Name: \_\_\_\_\_

Patient's Address: \_\_\_\_\_  
Street County City State Zip Code

Mailing Address: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Race: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Marital \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Status: Single \_\_\_ Married \_\_\_ Widowed \_\_\_

Employer: \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Name of someone not living in the same household: \_\_\_\_\_

\_\_\_\_\_  
Name Relationship Phone (\_\_\_\_)

\_\_\_\_\_  
Address City State Zip Code

**Responsibility for Bill**

**Do you currently reside in a skilled nursing facility? Yes No** Are you still employed? Yes \_\_\_ No \_\_\_

Insured's name: \_\_\_\_\_  
SS# \_\_\_\_\_ DOB \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ (\_\_\_\_)  
Company Name Address Phone

Are you a member of any HMO, PPO, or any other Managed Care Plan? Yes \_\_\_ No \_\_\_

**Medical Information**

What is the main reason for this doctor's visit? \_\_\_\_\_  
\_\_\_\_\_

How did you find out about our clinic? Dr. (Name: \_\_\_\_\_) Friend \_\_\_ Radio \_\_\_ Newspaper \_\_\_ TV \_\_\_

Who was the last eye doctor you saw? Dr's Name: \_\_\_\_\_

What was found? \_\_\_\_\_

Do you have medication reactions with any of the following?

Codeine \_\_\_ Sulfa \_\_\_ Penicillin \_\_\_ Eye Drops \_\_\_ Antibiotics \_\_\_ Anesthetics \_\_\_ None \_\_\_\_\_

List Others: \_\_\_\_\_

How many Cigarettes do you smoke a day? \_\_\_\_\_ How many alcoholic drinks per week? \_\_\_\_\_

Please list any operations you have had in the past: \_\_\_\_\_  
\_\_\_\_\_

**I certify that all information is complete and authorize the release of my medical information necessary to process insurance claims including HCFA and the payment of medical benefits to myself or the party who accepts assignment. This does include authorization to file through the Medigap Program. I authorize the release of my records to health care providers for the purpose of patient care. I consent for any and all clinical tests to be performed that are deemed necessary by my physicians of Southern Eye Center and I acknowledge receipt of information regarding the HIPAA privacy regulations.**

Patient's Signature

Date

**YOUR COMPREHENSIVE MEDICAL HISTORY**

Please check the appropriate box if you or a family member has had any of the following medical conditions.

Initials \_\_\_\_\_  
Date \_\_\_\_\_  
Account Number \_\_\_\_\_  
Patient Name \_\_\_\_\_

<b><u>Ear, Nose, and Throat</u></b>	<b><u>Present</u></b>	<b><u>Past</u></b>	<b><u>Family</u></b>	<b><u>Genito-Urinary</u></b>	<b><u>Present</u></b>	<b><u>Past</u></b>	<b><u>Family</u></b>
Sore Throat				Kidney Stones			
Deafness				Bladder Stones			
Ear Aches				Kidney Disorder			
Dry Mouth				Other _____			
<b><u>Lungs</u></b>				<b><u>Heart</u></b>			
Shortness of Breath				Chest Pains			
Bronchitis				High Blood Pressure			
Asthma				Heart Attack			
Emphysema				Fluid Retention			
TB				Pacemaker			
Other _____				Other _____			
<b><u>Gastro-Intestinal</u></b>				<b><u>Blood</u></b>			
Ulcer				HIV/AIDS			
Hernia				Blood Disease			
Intestinal Bleeding				Anemia			
Liver Disorder				Cancer			
Hemorrhoids				Other _____			
Other _____				<b><u>Joints</u></b>			
<b><u>Glands</u></b>				Arthritis			
Diabetes				Neuritis			
Thyroid Disorder				Back Disorder			
Other _____				Gout			
<b><u>Eyes</u></b>				Other _____			
Cataracts				<b><u>Reproductive System</u></b>			
Retinal Detachment				Prostate Disorder			
Eye Injury				Problems with the Breasts			
Other _____				Reproductive Disorder			
<b><u>Neurological</u></b>				Other _____			
Dizziness				<b><u>Psychiatric</u></b>			
Fainting				Depression			
Convulsions or seizures				Psychological Disturb.			
Other _____				Emotional Disturbance			
<b><u>Skin</u></b>				Other _____			
Rash							
Sores							
Psoriasis							
Eczema							

Please write down all prescription medications you are currently using, **including eye medications.**

<b>Medicine:</b>	<b>Why you take this medicine:</b>	<b>Medicine:</b>	<b>Why you take this medicine:</b>

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_ RN's Signature \_\_\_\_\_ Date \_\_\_\_\_ Tech Signature \_\_\_\_\_ Date \_\_\_\_\_