

**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: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Sex: M \_\_\_ F \_\_\_ Race: \_\_\_\_\_

Name of someone not living \_\_\_\_\_ (\_\_\_\_)  
in the same household: Name Relationship Phone

Address City State Zip Code

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

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

**Responsibility for Bill**

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.

	<u>Ear, Nose, and Throat</u>	<u>Present</u>	<u>Past</u>	<u>Family</u>	<u>Genito-Urinary</u>	<u>Present</u>	<u>Past</u>	<u>Family</u>
Initials	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			
Date	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			
Account Number	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			
Patient Name	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.**

Medicine:	Why you take this medicine:	Medicine:	Why you take this medicine:

Doctor's Signature
Date
RN's Signature
Date
Tech Signature
Date