EYE CENTER OF JASPER

PATIENT INFORMATION

Name: _____ DOB: _____

Social Security Number: _____

Single ____ Married ____ Widowed ____ Divorced_____ Age_____

Address : _____

City: _____ State_____ Zip Code: _____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email address: _____

Date of Last Eye Exam: _____ Primary Care Physician Name:_____

Preferred Pharmacy:_____ City/State:_____

IN CASE OF AN EMERGENCY-CONTACT

Name:_____ Contact Number:_____

Relation to you:_____

ASSIGNMENT OF BENEFITS FOR MEDIGAP OR OTHER INSURANCE

I hereby irrevocably assign and transfer to Eye Center of Jasper All rights and benefits whether contractual or statutory. Photocopy of this original shall be valid as original. I authorize any holder of medical information about me or any information needed to determine the benefits payable for related services to release to the Health Care Financing Administration, Medigap Insurer and other Insurer and its agents any information needed to determine these benefits payable for related services. In Medicare assigned cases, the provider agrees to accept the charge determination of Medicare.

My signature below further certifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

Patient Signature:_____

I AUTHORIZE THE EYE CENTER OF JASPER TO RELEASE ANY INFORMATION REGARDING MY MEDICAL HISTORY, DIAGNOSIS, CARE, TREATMENT OR PROGRESS TO THE FOLLOWING. WE MAY RELEASE ALL INFORMATION UNLESS OTHERWISE SPECIFIED TO:

NAME(S):_____

Patient Signature_____ **Date**_____

MEDICAL INSURANCE vs. VISION INSURANCE

INFORMATION SHEET

Eye Center of Jasper

Since you have medical insurance and vision insurance we would like to inform you that today's visit may not be strictly a routine eye exam depending on the doctor's findings during your visit. **Should you have a medical condition that needs proper professional monitoring and care, your charges today will be filed with your medical insurance as primary and your vision insurance as secondary**. It is a great advantage to you that you have two insurances we can use for your services today. You may use your vision insurance today for any materials that may be allowed by your vision insurance.

Patient Signature_____ **Date**_____

MEDICARE PATIENTS

Having Medicare means that you are responsible for the Medicare deductible and coinsurance should you not have a secondary that picks up this cost for you.

Also, Medicare **DOES NOT** cover refractions because this is not a medical procedure according to Medicare. **Therefore, there will be a $25.00 charge for this service**. If you have a secondary insurance please note that since Medicare does not cover this service neither will your secondary **UNLESS** your secondary insurance is Texas Medicaid.

By signing below, I understand how today's charges may be billed and I am aware that any balance such as copays, deductibles, coinsurance and any non-covered service or diagnostic test not covered by my insurance will be my responsibility.

_____ _____

Patient Signature/Responsible Party **Date**

PATIENT MEDICAL HISTORY

Name:_____ Date:_____

Please answer the following questions about your current medical status and medical history:

1) **Medications:** List any medications you are currently taking,(including aspirin, vitamins/supplements):

_____

_____

2) **Allergies:** Do you have any food or drug allergies(including latex, adhesives, shellfish or iodine)? __YES __NO

_____

_____

3) Have you ever been diagnosed with any ocular(eye) problems?(i.e. glaucoma, cataract, macular degeneration)
__YES __NO If Yes, please list: _____

_____

4) Have you ever had any ocular(eye) procedures? (i.e. cataract surgery, glaucoma surgery, retinal surgery, lasik)
__YES __NO If Yes, please list: _____

_____

5) Have you ever had any general surgeries/procedures?(i.e. gallbladder, cardiac, pacemaker, appendix, etc)
__YES __NO If Yes, please list: _____

_____

Do you have a pacemaker? __YES __NO

Please check all conditions that you have currently or have had in the past:		Please provide an explanation:
Diabetes		
Cancer		
High Cholesterol		
High Blood Pressure		
Chronic fever, unexpected weight loss/gain, fatigue		
Skin(e.g. rashes, excessive dryness, rosacea, skin cancer)		
Ear/Nose/Throat(e.g. hearing loss, sinus problems, sore throat, cough)		
Respiratory (e.g. asthma, emphysema, COPD, shortness of breath)		
Cardiovascular (e.g. heart disease, chest pain, irregular heart beat)		
Gastrointestinal(e.g. heart burn, ulcer, abdominal pain, diarrhea, vomiting)		
Urinary(e.g. kidney/bladder conditions, pain or discomfort, blood in urine)		
Musculoskeletal(e.g. arthritis, muscle aches, joint pain, swollen joints)		
Neurologic(e.g. stroke, numbness, headaches, paralysis		
Endocrine (thyroid)		
Psychiatric(e.g. depression, anxiety, panic attacks)		
Autoimmune(e.g. lupus, rheumatoid arthritis, HIV/AIDS, hepatitis)		
Environmental Allergies		

Race Association: __ White __Black __ Hispanic __Asian __Indian __Other

Family History

Have your parents, siblings or children been treated for any of the following?

Glaucoma_____ Macular Degeneration _____ Blindness _____

Diabetes _____ Cancer _____ Heart Disease _____

Social History

Do you drink alcohol? __YES __NO Do you smoke? __YES __NO Are you pregnant? __YES __NO Former smoker? __YES __NO