COLLIERVILLE EYE ASSOCIATES

PATIENT INFORMATION & HISTORY QUESTIONAIRE

Last Name:_____ First Name:_____ MI:_____ Nickname:_____

Address:_____ City:_____ST:_____Zip:_____ Gender: M F

Telephone: (H)_____ (W)_____ (Cell)_____Salutation: Mr Mrs Ms Dr Prof

Which phone number do you prefer we call first? Please circle: Home Work Cell

Email:_____SSN:_____ Date of Birth:_____/_____/_____

Occupation:_____Employer:_____ How did you hear about us? _____

MEDICAL INSURANCE

Primary Medical Insurance: _____ ID# _____

Primary Policyholder's Name: _____ Relation to Patient: _____

Policyholder's Date of Birth: _____/_____/_____ Policyholder's SSN: _____

Secondary Medical Insurance: _____ ID# _____

Secondary Policyholder's Name: _____ Relation to Patient:_____

Policyholder's Date of Birth: _____/_____/_____ Policyholder's SSN: _____

REASON FOR VISIT

Date of Last Eye Exam: _____ Last Eye Doctor: _____

What Concerns are you having with your Eyes / Vision? _____

_____

How many hours a day do you use a computer?_____

Do you wear contact lenses? YES NO If so, what brand & power_____

Your insurance requires that we ask: What is your Height_____ Weight_____

Are you allergic to any medication? YES NO If yes, please list:_____

What Medications Are You Currently Taking? (Prescribed, Over-the-Counter, and Eye)

_____

_____

Primary Care Physician:_____ Date of Last Visit: _____

Do you use any of the following: Alcohol O Yes O No If yes: how much _____

Tobacco O Yes O No If yes: cigars / cigarettes / pipe / smokeless

If yes, frequency: every day / some days / lite

Illegal Drugs O Yes O No If yes: What illegal drug _____

REVIEW OF SYSTEMS: Do you currently, or have you ever had problems in the following areas:

Eye	YES	NO	Vascular/Heart	YES	NO	Bones/Joints/Muscle	YES	NO
Loss of Vision	____	____	Diabetes	____	____	Rheumatoid arthritis	____	____
Blurred Vision	____	____	High blood pressure	____	____	Joint pain	____	____
Double Vision	____	____	Heart pain	____	____	Ear/Nose/Throat		
Eye Injury	____	____	Neurological			Allergies/Hay Fever	____	____
Eye Surgery	____	____	Headaches	____	____	Genitourinary/Hematologic		
Flashes/Floaters	____	____	Migraines	____	____	Kidney/Bladder/other	____	____
Glare/ Halos	____	____	Seizures	____	____			
Crossed/lazy eye	____	____	Respiratory					
Cataracts	____	____	Asthma	____	____			
Glaucoma	____	____	Chronic bronchitis	____	____	Are you currently pregnant? YES NO		
Eye pain/sorenesss	____	____	Emphysema	____	____	If yes, how far along are you:_____		
Endocrine			Skin Disorders	____	____			
Thyroid	____	____	Psychiatric	____	____	Are you currently breastfeeding? YES NO		

OUR FINANCIAL POLICY

We appreciate your trust in us and we appreciate the opportunity to serve you. We are committed to providing the highest level of eye care to our patients. To ensure that our patients fully understand our billing process, we ask that you read and sign this financial policy statement.

PATIENT PAYMENTS - Payment is due **at the time of service**. You may use cash, check, credit card, or debit card to pay your account. **INSURANCE COVERAGE** - We make a good faith attempt to verify your insurance coverage. We are not able to guarantee that the information given to us by your insurance is correct. It is your responsibility alone to know what insurance plan you are on, supply us with the correct information at the time of your visit and know what services may or may not be covered by your insurance. **INSURANCE PAYMENTS** - Regarding insurance, your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We require certain co-payments, deductibles or prepayment amounts depending on the type of insurance and insurance carrier. Be assured our office works diligently to obtain payment from your insurance company**. ESTABLISHED PATIENTS / MISSED / LATE CANCELLED APPOINTMENTS** - Please give us at least *24 working hours* notification if you cannot keep an appointment. This courtesy will allow others to be seen. We do realize that emergencies arise.**RETURNED CHECKS** - Our bank charges us whenever a patient presents a check that does not have funds available. Therefore, we must charge you a $35.00 handling fee. All future visits will need to be paid with either cash or a credit card.

PATIENT AUTHORIZATION

I have read, understand, and agree to abide by the terms stipulated above. I request that payment of benefits be made to Collierville Eye Associates. I hereby authorize the release of any information necessary to determine liability for payment and obtain reimbursement on any claim. I further authorize the use of my signature below on all insurance submissions for services rendered or to be rendered. I agree that a photocopy of this agreement shall be as valid as the original.

Patient Name _____ **Date of Birth** _____

Patient Signature _____**Date**_____

PRIVACY - By signing, I attest that I am either the patient being seen or the parent/legal guardian of this minor being seen. I certify that I have read and understood the above information to the best of my knowledge and that I have provided the information as accurately as possible. I understand that providing incorrect information can be dangerous to my health. I give permission for the doctor(s) to examine, diagnose, and initiate treatment as deemed appropriate. I authorize the doctor to release any information including the diagnosis and a summary of any treatment or examination rendered to me or my child to appropriate third party payers or other health care providers. I authorize and request my insurance company to pay all appropriate benefits directly to the doctor. I understand my insurance carrier may pay less than the actual amount of the fee for services and materials and I agree to be responsible for payment of all uncovered services and supplies rendered on my behalf or my dependents. I authorize the doctor and/or Collierville Eye Associates, PLLC employees to contact me by phone, email, or written correspondence concerning future eye exams or pertinent eye health issues. I acknowledge that I have been given the opportunity to read a copy of the privacy practices of Collierville Eye Associates, PLLC.

Patient Name _____ **Date of Birth** _____

Patient Signature _____**Date**_____

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, DOB ___/____/____ authorize and request that _____ release the following information to _____(name) _____(address) _____(telephone) Information being release will be used for this purpose, and only this purpose: _____

(_)Eye glasses prescription (_)Contact lens prescription (_) Medication prescription (_) All medical records _____ I understand that if my medical record contains information concerning HIV (AIDS) or drug or alcohol abuse, those portions of my medical record are protected by state or federal law. I hereby release and forever discharge Collierville Eye Associates, it's physicians and employees, or agents from any liability arising out of the release of my medical record as specified above and pursuant to this signed authorization. This consent is subject to written revocation at any time*, except to the extent that the disclosure has already taken place in reliance on it.

_____ ____/____/____ Signature of patient/parent/legal guardian

_____ nature of relationship

I give my permission for the physicians and/or staff of Collierville Eye Associates, PLLC to release my health information and/or financial information as indicated below:

____ Information may be left on the home, work, or cellular voicemail requesting that I call the office

____ Information may be shared with the following individuals:

Please list all names that apply and relationship:

(Name)_____ (Relationship) _____

(Name)_____ (Relationship) _____

(Name)_____ (Relationship) _____

Signature:_____Date:_____