Thank you for entrusting us with your vision care. We look forward to serving you in a caring, efficient and professional manner.

During your first visit it will be necessary to create your medical record. We would appreciate your assistance in expediting this process. Please complete the enclosed Patient Information / Insurance Information (two-sided), Eye Patient Health History and Notice of Non-Covered Services forms. By completing this step in advance we can better focus on meeting your eye care needs during your visit.

We have also enclosed a copy of our Notice of Privacy practices for your review.

We respectfully request that you arrive fifteen minutes prior to your scheduled appointment time. This will allow us to verify your information and enter it into our computer system prior to your visit with the doctor.

Please plan to bring with you to your appointment the following:

- **Completed forms** – Patient/Insurance Information (front and back), Eye Patient Health History, and Notice of Non-Covered Services.

- **Your insurance card.**

- **Payment for co-pays, deductibles, co-insurance amount and any services not covered by your insurance.** We accept cash, checks and credit cards. Payment is expected at the time of service.

- **Referral** – if your insurance requires it, otherwise payment is expected at the time of service.

We are very pleased that you have chosen us for your eye care. Feel free to call our office if we can be of assistance to you in completing this paperwork or with any other questions you might have about your appointment.

We look forward to seeing you!

Kim Southmayd
Practice Administrator
PATIENT INFORMATION

Patient’s Last Name ____________________________  First __________________ MI ______
(Please Print)  Preferred Name ____________________________

Social Security # ___________________ Age _____ Sex _____ Race _____ Birthdate ______

Address __________________________________________ Marital Status: M S D W

City ___________________________ State ______ Zip __________

Cell Phone# _____________ Home Phone# _____________ Work Phone # _____________

May we leave detailed personal health information on your contact phone number voicemail?
This information may include pathology results, lab results, appointments, etc.
Home Phone: Yes[ ] No[ ]  Cell Phone: Yes[ ]  No[ ]  Business Phone: Yes[ ]  No[ ]

Who may we discuss your health information with?
No one other than self[ ]  Spouse[ ]  Parent[ ]  Voicemail[ ]  Other[ ]

Name and Address of Employer __________________________________________

Name of Spouse or Parent/Guardian __________________________________________
(if patient is under 18 yrs of age)

Spouse Work Phone# _______________ Spouse Cell Phone# _______________

Family Doctor ___________________________ Name of Clinic ___________________________

Emergency Contact ___________________________ Relationship _______________ Phone# _______________
(Friend or Relative not living with you)

I HEREBY ACKNOWLEDGE HAVING READ OR RECEIVED THE NOTICE OF INFORMATION PRACTICES.

I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PROVIDER WHO ACCEPTS ASSIGNMENT. I UNDERSTAND ANY COPAYs AND NON-COVERED SERVICES ARE TO BE PAID AT THE TIME OF SERVICE.

I WILL NOTIFY THE EYE CENTER WITHIN 24 HOURS OF MY APPOINTMENT IN THE EVENT THAT I AM UNABLE TO ATTEND; FAILURE TO DO SO MAY RESULT IN A $30.00 CANCELATION FEE.

Patient’s Signature: ___________________________ Date: ___________________________
(Parent or Guardian if under 18)
# Insurance Information

**Primary Insurance**

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<thead>
<tr>
<th>Primary Insurance</th>
<th>Policy #</th>
<th>Group #</th>
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<table>
<thead>
<tr>
<th>Insured Name</th>
<th>Insured DOB</th>
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<tbody>
<tr>
<td>Insured Address</td>
<td>Insured SS#</td>
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<tr>
<td>Insured Cell Ph#</td>
<td>Insured Home Ph#</td>
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<td>Insured Work Ph#</td>
<td>Insured Relationship to Patient</td>
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**Secondary Insurance**

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<th>Secondary Insurance</th>
<th>Policy #</th>
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<td>Insured Work Ph#</td>
<td>Insured Relationship to Patient</td>
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**Guarantor**

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<th>Guarantor</th>
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<td>Guarantor Home Ph#</td>
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<td>Guarantor Work Ph#</td>
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<th>Insured Employer</th>
<th>Insured Relationship to Patient</th>
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*Guarantor* *(if different from patient or insured)*
# EYE PATIENT HEALTH HISTORY

Patient's Last Name ___________________________ First _______ MI _______ Preferred Name ___________________________

Race _______ Date of Birth ___________ Pharmacy Preference (include location) ___________________________

Name of Primary Care (Family) Physician ___________________________ Name of referring physician ___________________________

Are you taking any kind of MEDICATION now? (This includes prescription, over-the-counter or herbal medications)
[ ] No [ ] Yes If yes, please list below.

<table>
<thead>
<tr>
<th>NAME, DOSE and HOW OFTEN</th>
<th>Problem being treated</th>
<th>Date of Prescription</th>
<th>Prescribing Doctor</th>
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Are you ALLERGIC to any medication? [ ] No [ ] Yes If yes, please list below.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Type of Reaction</th>
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**PAST MEDICAL HISTORY**
Have you ever been diagnosed with a major health problem? (Ex. diabetes, asthma, glaucoma) [ ] No [ ] Yes (List)

__________________________________________________________________________________________________________

Have you ever had a serious EYE INJURY or SURGERY ON YOUR EYES? [ ] No [ ] Yes (List)

__________________________________________________________________________________________________________

**FAMILY HISTORY**
Are there any EYE PROBLEMS that seem to run in your family such as glaucoma [ ] No [ ] Yes (List)

__________________________________________________________________________________________________________

**SOCIAL HISTORY**
What is or was your occupation? ___________________________ [ ] Check here if you are retired. Marital Status ___________________________

Do you currently smoke? [ ] No [ ] Yes

Living setting: [ ] Alone [ ] Spouse [ ] Children [ ] Mother [ ] Father [ ] Nursing Home [ ] Assisted living [ ] other ___________________________

**REVIEW OF SYSTEMS** List any problems you have or have had recently in the following areas.

General Health: (fever, weight loss or gain, problems sleeping, fatigue, weakness, etc.) [ ] No [ ] Yes

__________________________________________________________________________________________________________

Eyes: problems that have not been corrected by glasses (visual loss, double vision, blurred vision, etc.) [ ] No [ ] Yes

__________________________________________________________________________________________________________
The Eye Center of Oak Ridge, P.C.

Notice of Non-Covered Services

**REFRACTION** (Measurement to check how well you can see)

As part of your examination, it may be necessary for us to measure how well you can see. This test is called a "refraction". In some situations, it will be necessary for us to perform this measurement to fully evaluate your eye condition, even if you do not desire new glasses.

Medicare and most other insurance companies **will not** pay for services they consider to be non-covered services. You will be responsible for such services at the time of your examination.

**REFRACTION FEE:** $35.00

We will be happy to answer any questions you may have.

Signature: ___________________________ Date: ___________________________
Patient or Parent/Legal Guardian

Signature: ___________________________ Date: ___________________________
Patient or Parent/Legal Guardian

Signature: ___________________________ Date: ___________________________
Patient or Parent/Legal Guardian

Signature: ___________________________ Date: ___________________________
Patient or Parent/Legal Guardian

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Rev 07/13