# 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 _____ Home Phone #_____

Cell Phone # _____ Work Phone # _____

E-Mail _____

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** _____ POLICY # _____ GROUP #_____

Insured Name _____ Insured DOB _____

Insured Address _____ Insured SS# _____

Insured Cell Ph# _____ Insured Home Ph# _____ Insured Work Ph# _____

Insured Employer _____ Insured Relationship to Patient _____

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**SECONDARY INSURANCE** _____ POLICY # _____ GROUP #_____

Insured Name _____ Insured DOB _____

Insured Address _____ Insured SS# _____

Insured Cell Ph# _____ Insured Home Ph# _____ Insured Work Ph# _____

Insured Employer _____ Insured Relationship to Patient _____

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**GUARANTOR** _____ Guarantor DOB _____
(if different from patient or insured)

Guarantor Name _____ Guarantor DOB _____

Guarantor Address _____ Guarantor SS# _____

Guarantor Cell Ph# _____ Guarantor Home Ph# _____ Guarantor Work Ph#_____

Insured Employer _____ Insured Relationship to Patient _____

# 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.

| NAME, DOSE and HOW OFTEN | Problem being treated | Date of Prescription | Prescribing Doctor |
|---|---|---|---|
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Are you ALLERGIC to any medication? ☐ No ☐ Yes If yes, please list below.

| Name of Medication | Type of Reaction |
|---|---|
| | |
| | |
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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 Financial Policy

1. ***INSURANCE*** We participate in most primary insurance plans, including Medicare. We will also file any secondary insurance as a courtesy. *Knowing and understanding YOUR insurance benefits is YOUR responsibility.* If you are not insured by a plan we are in contract with, payment in full is expected at each visit. If you are insured by a plan we are in contract with but do not have an up to date insurance card, payment in full is expected.
2. ***CO-PAYMENTS AND DEDUCTIBLES*** All co-payments and deductibles must be paid at the time of service. This arrangement is part of the contract with your insurance company.
3. ***CO-INSURANCE*** After your insurance processes the claims, you will be billed for any co-insurance or patient responsibility according to your insurance contract.
4. ***REFERRALS*** Some insurers require referrals for services. It is YOUR responsibility to obtain referrals. If you did not obtain a referral prior to services, you will be responsible for the balance.
5. ***CLAIMS SUBMISSION*** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. IT IS YOUR RESPONSIBILITY TO COMPLY WITH THEIR REQUEST. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefit is a contract between you and your insurance company. We are not a party to that contract.
6. ***NON-PAYMENT*** If your account is over 90 days past due, we will turn your account over to our collection agency.
7. ***NON-COVERED SERVICES*** Please be aware that some and perhaps all of the services you receive may be non-covered or considered not reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit. **Initial** _____

   Example: ***REFRACTION FEE $40.00 (Measurement to check how well you can see.)***

**Please sign below to indicate that you have read and you fully understand our Financial Policy.**

_____

**Patient Name (Please print)**

_____ _____

**Patient or Guarantor Signature** **Date**