Deer Eye Clinic
Patient Information

Personal Information (Please Print)

Name _____ Date of Birth_____ Male ☐ Female ☐
Address _____ Soc Sec # _____
Street City State Zip
Hispanic ☐ Not Hispanic ☐ Decline ☐
Phone Home (_____) _____ Cell (____) _____ E-Mail _____
Family Physician _____
Occupation _____ Employer _____
Employer Address _____ Work Phone (_____) _____
Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐
Spouse Name: _____ Date of Birth: _____ Phone (_____) _____
Employer _____ Work (_____) _____

Complete if Under 18 Years or a Student

Name of Father _____ Date of Birth _____ Phone (_____) _____
Address _____ Soc Sec # _____ Phone (_____) _____
Name of Mother _____ Date of Birth _____ Phone (_____) _____
Address _____ Soc Sec # _____ Phone (_____) _____

Insurance Information

Name of Insurance Company _____
Name of Policy Holder _____ Date of Birth _____
Address _____
Social Security #_____ Phone # _____ Relationship to Patient _____
Secondary Insurance or Vision Plan_____
Name of Policy Holder _____ Date of Birth _____
Address _____
Social Security #_____ Phone # _____ Relationship to Patient _____

Referred By: Friend/Relative _____ Yellow Pages _____ Newspaper _____ Other _____
Who to notify in emergency (nearest relative or friend)?
Name _____ Relationship _____Home (_____) _____
Address _____ Cell (_____) _____ Work(_____) _____

Financial Assignment and Agreement

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, any other balance not paid for by your insurance, and any collection agency fees.**
2. **In order to control your cost of billings, we request that your charges for office visits be paid at the conclusion of each visit unless you are covered by Medicare.**
3. I request that payment of authorized Medicare and/or insurance benefits be mad on my behalf for any services furnished me. I authorize that any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed (Patient or Parent if Minor) _____ Date _____

Chart # _____ Provider _____

DEER EYE CLINIC

Philip J. Deer, Jr., M.D.
Philip J. Deer, III, M.D.

CANCELLATION AND MISSED APPOINTMENT POLICY

We understand that situations arise in which you must cancel your appointment. Our Physicians request that if you must cancel your appointment you provide more than 24 hours' notice.

Effective August 16, 2016 a $30.00 missed appointment fee will be charged on all missed appointments, and appointments cancelled with less than a 24-hour notification. We want to insure the best possible physician availability to all of our patients. The missed appointment fees are the sole responsibility of the patient and must be paid in full before the patients next appointment can be scheduled.

I do know and understand that my insurance, Medicare, and/or Medicaid will not be billed for the missed appointment fee. I am responsible for the missed appointment fee.

Please sign that you have read, understand and agree to this Cancellation Policy.

_____ _____

Signature of Patient or Patient Representative **Date**

OPHTHALMOLOGY ▪ OPHTHALMIC SURGERY
4942 WEST MARKHAM ▪ LITTLE ROCK, AR 72205
501-224-4701

Deer Eye Clinic
Medical History Questionnaire

Name: _____ Date: _____

Date of Birth: _____ Date of last eye exam: _____

List any medications (with the dosage and frequency in which you take them) you currently take (prescription and over-the-counter): _____
_____

Do you have any allergies to any medications or latex? (Circle one) **YES** **NO**
If YES, list the medications and your reaction to them: _____
_____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, congestive heart failure etc.) or injuries (concussion, etc.)_____
_____

List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.) _____

PERSONAL MEDICAL HISTORY

Eyes

(CHECK ALL BOXES OF ANY SYPTOMS THAT YOU ARE CURRENLY EXPERIENCING)

	No Complaints
	Decrease in Vision
	Decrease in Peripheral Vision
	Decrease in Central Vision
	Distorted Vision
	Scotoma (partial vision loss/blind spot)
	Fluctuating Vision
	Dim Vision
	Double Vision
	Fuzzy Vision
	Hazy/Foggy Vision
	Glare
	Blur
	Haze
	Halos
	Flashes
	Floaters
	Flashes/Floaters
	Black Spots
	Veil/Cobwebs
	Headache
	Throbbing

	Burning Pain
	Sharp Pain
	Scratchy
	Foreign Body Sensation
	Irritation
	Dull Pain/Aching
	Photophobia (light sensitivity)
	Dry/Burning
	Itching
	Tearing
	Discharge
	Sticking Lids
	Mattering
	Redness
	Puffy Eyes
	Tired Feeling
	Sting
	Swollen
	Lump
	Yellow
	Other:

CONTINUED ON NEXT PAGE

CHECK THE BOX IF YOU EXPERIENCE OR ARE DIAGNOSED WITH ANY OF THE FOLLOWING:

If none apply, please mark None of the Above

	CONSTITUTIONAL
	Fatigue
	Malaise
	Chills
	Fever
	Night Sweats
	Appetite Changes
	Weight Changes
	Other: _____
	None of the Above

	RESPIRATORY
	COPD
	Wheezing
	Cough
	Hemoptysis
	Asthma
	Tuberculosis
	Shortness of Breath
	Other: _____
	None of the Above

	HEAD, EARS, NOSE AND THROAT
	Head Injury
	Decreased Hearing
	Tinnitus
	Earache
	Hay Fever
	Sinus Pain
	Stuffiness
	Discharge
	Dry Mouth
	Sore Throat
	Dentures
	Difficulty Swallowing
	Other: _____
	None of the Above

	Gastrointestinal
	Diarrhea
	Constipation
	Stool Changes
	Hemorrhoids
	Indigestion
	Difficulty Swallowing
	Nausea/Vomiting
	Other: _____
	None of the Above

	CARDIOVASCULAR
	Agina
	Heart Attack
	High Cholesterol
	High BP
	Low BP
	Murmur
	Thrombophlebitis
	Varicose Veins
	Other: _____
	None of the Above

	GENITOURINARY
	Blood
	BHP
	Difficult Urination
	Enlarged Prostate
	Increased Frequency
	Frequent UTIs
	Incontinence
	Kidney Stones
	Other: _____
	None of the Above

	DERMATOLOGICAL
	Rash
	Lump
	Itching
	Dryness
	Other: _____
	None of the Above

CONTINUED ON NEXT PAGE

PERSONAL MEDICAL HISTORY CONTINUED

	MUSCULOSKELETAL
	Arthritis
	Swelling
	Stiffness
	Muscle Aches
	Muscle Weakness
	Leg Cramps
	Back Pain
	Joint Pain
	Other: _____
	None of the Above

	PSYCHIATRIC
	Depression
	Nervousness
	Anxiety
	Memory Loss
	Panic Attacks
	Mania
	Other: _____
	None of the Above

	ENDOCRINE
	Polydipsia
	Hypoglycemia
	Diabetes
	Hypothyroid
	Hyperthyroid
	Goiter
	Heat/Cold Intolerance
	Other: _____
	None of the Above

	NEUROLOGICAL
	Alzheimer's
	Dizziness
	Headaches
	Migraine
	Multiple Sclerosis
	Parkinson's Disease
	Seizures
	Stroke
	TIA
	Tremors
	Other: _____
	None of the Above

	HEMATOLOGIC
	Ease of Bruising
	Excessive Bleeding
	Enlarged Lymph Nodes
	Anemia
	Other: _____
	None of the Above

FAMILY HISTORY M= mother F= father S= Sibling GP= grandparent

Disease	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease			
High Blood Pressure			
Kidney Disease			
Lupus			
Stroke			
Thyroid disease			
Other			

CONTINUED ON NEXT PAGE

SOCIAL HISTORY

Current occupation: _____

Education (high school, vocational school, college degree): _____

Marital Status (married, divorced, single, widowed):_____

Do you drive?	**YES**	**NO**
Do you have visual difficulty when driving?	**YES**	**NO**
Do you have problems with night vision?	**YES**	**NO**
Have you ever tried to wear contact lenses?	**YES**	**NO**
Do you currently wear contact lenses?	**YES**	**NO**
Do you currently wear glasses?	**YES**	**NO**

Do you drink alcohol?	**YES**	**NO**	If YES:	Occasional	1/day	2-3/day	4+/day
Do you smoke?	**YES**	**NO**	If YES:	Occasional	½ pack/day	1 pack/day	1+ pack/day

Patient's Signature _____ **Date:** _____

Physician's Signature _____ **Date:** _____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____ have received a copy of DEER PENICK EYE CLINIC
(Patient's Name)

Clinic's Notice of Privacy Practices.

_____ _____
Signature of Patient *Date*

I elect the person(s) below as my account representatives. This will allow them access to information regarding my account and medical history.

Name _____

Name _____

Name _____

Name _____

Name _____

Name _____

DEER EYE CLINIC

Refraction Service and Fee

The refraction test is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contacts.

Most medical insurance plans, including Medicare, do NOT cover routine refractions or routine eye examinations (when no medical eye problem is known or suspected). Medicare allows that we charge separately for that portion of the examination, since it is not a covered service.

If you have a separate vision plan that covers routine or annual eye examinations and/or glasses, please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan.

Our office fee for a refraction is $30.00, and this fee is collected at the time of service in addition to any copayment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

Patient Acknowledgement

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at time of service. I understand that any copayment, coinsurance, or deductible I may have are separate from and not included in this refraction fee.

X_____

Patient signature (parent for minor)/ Date