EYE ASSOCIATES OF THE SOUTH, PLLC
PATIENT INFORMATION FORM

PATIENT INFORMATION

Last Name:_____ First:_____ M.I._____ Sex: ☐ M ☐ F
Social Security #_____ Date of Birth:_____ Age:_____
Address:_____
City:_____ State:_____ Zip:_____Home #_____Cell #_____
Name of Employer:_____ Phone:_____

GUARANTOR INFORMATION (IF PATIENT IS UNDER 18 YEARS OF AGE)

Last Name:_____ First:_____ M.I._____ Sex: ☐ M ☐ F
Social Security #_____ Date of Birth:_____ Age:_____
Address:_____
City:_____ State:_____ Zip:_____ Home #_____Cell #_____
Name of Employer:_____ Phone:_____

PRIMARY INSURANCE INFORMATION: (PLEASE PROVIDE INSURANCE CARDS FOR US TO PHOTOCOPY).

Name of Insurance Company:_____
ID/Policy #:_____Group #:_____
Name of card holder (if not patient):_____Social Security #:_____
Date of Birth:_____ Relationship to patient : **SELF SPOUSE CHILD OTHER**_____
Employer name:_____Phone#:_____
Address _____City_____State_____Zip_____

DO YOU HAVE A ROUTINE VISION PLAN SEPARATE FROM YOUR MEDICAL COVERAGE? YES___NO___
If yes, please provider vision plan information.

SECONDARY INSURANCE INFORMATION:

Name of Insurance Company:_____
ID/Policy #:_____Group #:_____
Name of card holder (if not patient):_____Social Security #:_____
Date of Birth:_____ Relationship to patient : **SELF SPOUSE CHILD OTHER**_____
Employer name:_____Phone#:_____
Address _____City_____State_____ Zip_____

HIPPA INFORMATION: Instructions for the office when returning phone calls or reminding you about appointments.
I authorize the office to contact me at: ☐ Home ☐ Work ☐ Cell and May leave messages at: ☐ Home ☐ Work ☐ Cell
I authorize the office to leave detailed messages about appointments/phone calls: ☐ YES ☐ NO
The following information may be given to the individuals listed below: appointment time, procedures, billing/finance, medications, test/lab results, and any other information regarding my health.
1._____2._____ 3._____4._____

The information that I have provided is true to the best of my knowledge. I authorize any insurance benefit to be paid directly to Eye Associates of the South, PLLC. I authorize the release of any medical information needed to process my insurance claims. As a courtesy to me, Eye Associates of the South may submit claims to my primary and secondary insurance carrier, if applicable. I understand that I am financially responsible for any balance not paid by my insurance, including copays, deductibles, and non-covered services. I understand that if my account goes to an outside collections agency there is a $25.00 charge added to my balance.

PATIENT'S SIGNATURE_____ **DATE** _____

EYE ASSOCIATES OF THE SOUTH
MEDICAL FORM

Patient's Name: _____ Date of Birth: _____ Date: _____

PAST MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY AND NONE IF NONE APPLY)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplant
BPH
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
NONE
Other_____

PAST SURGICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY AND NONE IF NONE APPLY)

Appendix Removed
Bladder Removed
Breast Biopsy (Right, Left, Both)
Lumpectomy (Right, Left, Both)
Mastectomy (Right, Left, Both)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Heart: Biological Valve Replacement
Heart: Coronary Artery Bypass
Heart: Heart Transplant
Heart: Mechanical Valve Replacement
Heart: PTCA
Joint Replacement, Hip (Right, Left, Both)
Joint Replacement, Knee (Right, Left, Both)
Kidney Removed (Right, Left)
Liver: Hepatectomy
Liver: Liver Transplant
Liver: Shunt
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries Removed: Ovatrian Cyst
Ovaries: Tubal Ligation
Pancreas: Pancreatectomy
Prostate Biopsy
Prostate Removed: Prostate Cancer
Prostate: TURP
Rectum: APR
Rectum: Low Anterior Resection
Skin: Basal Cell Cancer Surgery
Skin: Melanoma
Skin: Skin Biopsy
Skin: Squamous Cell Carcinoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Uterus (Hysterectomy): Fibroids
Uterus (Hysterectomy): Uterine Cancer
Uterus (Hysterectomy): Cervical Cancer
NONE

Other_____

Patient's Name: _____ Date of Birth: _____ Date: _____

PEDIATRIC HISTORY (FOR DR EUSTIS PATIENTS ONLY)

Gestational Age at Birth: _____weeks

Birth Weight: _____lbs _____oz

Maternal Illnesses during pregnancy:

_____

Forceps Delivery: YES NO

OCULAR HISTORY: (PLEASE CIRCLE ALL THAT APPLY AND NONE IF NONE APPLY)

Allergic Conjunctivitis
Blepharitis
Cataract (Left eye, Right eye)
Contact Lenses
Corneal Dystrophy (Left eye, Right eye)
Diabetic Retinopathy, Background (Left, Right eye)
Diabetic Retinopathy, Proliferative (Left, Right eye)
Dry Eyes
Glasses
Glaucoma (Left eye, Right eye)
Macular degeneration (Left eye, Right eye)
Macular ERM (Left eye, Right eye)
Narrow angles (Left eye, Right eye)
Ocular Hypertension (Left eye, Right eye)
Ophthalmic Migraine
Pseudoexfoliation
Retinal tear (Left eye, Right eye)
Strabismus
PVD (Left eye, Right eye)
Vitreous floaters (Left eye, Right eye)
NONE
Other: _____

OCULAR SURGERY: (PLEASE CIRCLE ALL THAT APPLY AND NONE APPLY)

Blepharoplasty (Left eye, Right eye, both)
Cataract surgery (Left eye, Right eye, both)
Corneal transplant (Left eye, Right eye, both)
DASEK (Left eye, Right eye)
Eye Muscle Surgery
Intravitreal injections (Left eye, Right eye)
LASIK (Left eye, Right eye)
LPI (Left eye, Right eye)
LTP (Left eye, Right eye)
PRK (Left eye, Right eye)
Ptosis repair (Left eye, Right eye)
Punctal plugs (Left eye, Right eye)
Strabismus surgery
Retinal laser (Left eye, Right eye)
Trabeculectomy (Left eye, Right eye)
Tube shunt (Left eye, Right eye)
YAG capsulotomy (Left eye, Right eye)
NONE
Other: _____

MEDICATIONS: (PLEASE LIST ALL CURRENT MEDICATIONS; DOSAGES ARE NEEDED)

_____ _____
_____ _____
_____ _____
_____ _____

NONE

ALLERGIES: (PLEASE LIST ALL ALLGERIES)

_____ _____
_____ _____
_____ _____

NONE

Patient's Name: _____ Date of Birth: _____ Date: _____

SOCIAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Cigarette Smoking:

- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Illicit Drug Use:

- Drug use
- IV Drug Use
- NONE

Alcohol Use:

- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Safety:

- I feel safe at home.
- I do not feel safe at home.

FAMILY HISTORY: CIRCLE ALL THAT APPLY AND INCLUDE RELATIONSHIP TO PATIENT, MOTHER, FATHER, ETC)

MEDICAL HISTORY AND RELATIONSHIP

Hypertension: _____
Diabetes: _____
Cancer: _____
Heart Disease: _____
Stroke: _____
Migraine: _____

OCULAR HISTORY AND RELATIONSHIP

Cataracts: _____
Glaucoma: _____
Retinal Detachment: _____
Strabismus: _____
Macular Degeneration: _____
Corneal Dystrophy: _____
Ocular Herpes: _____

Other: _____

PHARMACY:

Pharmacy Name: _____ Phone #_____
Address: _____ City_____ State_____ Zip_____

MEDICAL VS VISION INSURANCE

One of the most challenging billing issues in an ophthalmology office has to do with if we should be billing the medical insurance or vision plan.

An ophthalmologist is a medical doctor (just like your family doctor or cardiologist) and provides very comprehensive medical eye exams, however, they also provide routine exams for people with no eye disorders.

For patients with both medical and vision coverage:

Your vision insurance is intended to provide you with a baseline eye evaluation. If you are being evaluated for medical reasons (corneal disorders, diabetes, cataracts, glaucoma, double vision, dry eyes, etc.), you are being provided with medical care. Vision insurance companies do not provide or limits coverage for medical care. Therefore; we will be billing your medical insurance for visits related to medical complaints and problems.

Which plan do you feel would better fit your needs for today's exam? **MEDICAL OR VISION**

_____ _____ _____

Patient's signature Date Physician's signature

EYE ASSOCIATES OF THE SOUTH

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Biloxi, MS 39532
Phone: 228•396•5185
Fax: 228•396•5186
www.2020view.com

Ocean Springs
Phone: 228•872•4444
Gulfport
Phone: 228•575•4488

NO- SHOW POLICY

No- Shows limit access to medical care for other patients. Office appointments cancelled with less than one business day notification and arrivals more than 15 minutes-late are also considered NO-SHOWS.

We kindly request that you provide at least one business day cancellation-notice during business hours, so we can offer the time slot initially reserved for you to another family who needs it. We understand that situations may arise in which you must cancel your appointment.

Patients who No-Show a Double Appointment, (bringing in two family members at the same time), will be restricted from scheduling double appointments in the future. A note will be entered into the Practice Management System. A no- show fee will charged for each patient scheduled.

NO SHOWS ARE SUBJECT TO A $25.00 FEE.

The No-Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment is scheduled.

Our practice firmly believes that a successful provider- patient relationship is based upon understanding, good communication and mutual respect. We trust that you will be here for the time we scheduled just for your appointment.

-THANK YOU-

Please sign that you have read, understand and agree to this No- Show Policy.

_____ _____

Patent Name (Please print) Date of birth

_____ _____

Signature of Parent or Patient Representative Date

JOEL M. KNIGHT, M.D.
Diseases & Surgery of the Eye
General Ophthalmology with
Vitreous Retina Specialty

RAINNA P. BAHADUR, M.D.
Cornea & External Disease
Refractive Surgery

DEBRA L. LAPRAD, M.D.
Disease & Surgery of the Eye
General Opthalmology

KIMBERLY R. BENIGNO, O.D.
Contact Lens Fitting
Comprehensive Eye Exams

H. SPRAGUE EUSTIS, M.D.
Disease & Surgery of the Eye
Pediatric Ophthalmology

MARK S. BROWN, M.D.
Cosmetic & Reconstructive Surgery
Eyelids Orbit & Lacrimal System