VIDALIA EYE ASSOCIATES
700 MAPLE DRIVE
VIDALIA GA 30474
912-537-1991 / 1-888-451-6001

DUBLIN EYE ASSOCIATES
18 ERIN OFFICE PARK
DUBLIN GA 31021
478-272-5933 / 1-800-342-6000

Please Date Here➤➤➤➤

DATE INFORMATION IS COMPLETED: _____

Demographic Information……

Name: _____

Address: _____

City/State/Zip: _____

Home Phone #: _____ Cell # : _____

Email Address: _____

Date Of Birth: _____ Social Security #: _____

Gender: ❍ Male ❍ Female Race: _____

Marital Status: ❍ Single ❍ Married ❍ Divorced ❍ Separated ❍ Widowed
If Married – spouse's name: _____

Emergency Contact: _____ Phone #: _____

Employment Information……

Employment Status: ❍ Full-Time ❍ Part-Time ❍ Retired ❍ Not Employed ❍ Military

Employer: _____
Occupation: _____
Business Address: _____
Business Phone: _____

Insurance Information……

Primary: _____
Policy #: _____ Group #: _____

Secondary: _____
Policy #: _____ Group #: _____

THIS OFFICE FILES YOUR MEDICAL INSURANCE COMPANY AS A COURTESY. THIS OFFICE DOES NOT FILE OR ACCEPT ANY VISION INSURANCE PLANS. YOU ARE ULTIMATELY RESPONSIBLE FOR PAYMENT OF ALL SERVICES YOU RECEIVE. PLEASE PROVIDE US WITH YOUR MEDICAL INSURANCE CARD SO THAT WE MAY HAVE AS MUCH INFORMATION AS POSSIBLE. OTHERWISE, PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

SIGN HERE PLEASE! ☞ **PATIENT'S SIGNATURE:** _____ **DATE:** _____

VIDALIA EYE ASSOCIATES **DUBLIN EYE ASSOCIATES**

Medical History Form

SIGN HERE PLEASE! **PATIENT'S NAME:** _____ **DATE:** _____

Do you have now or have you ever had: -- please answer all questions – Indicate YES or NO. If the answer is YES, please provide a brief explanation.

For Office Use Only	Diagnosis	Yes	No	Explanation
E11	Diabetes			
I25.2	Heart Attack			
I20.9 / R07.9	• Angina Or Chest Pain			
I50.9	• Congestive Heart Failure			
I49.9	• Irregular heartbeat			
I48.9	• Atrial Fibrillation (AFIB)			
Z95.0	• Cardiac Pacemaker			
I10	High Blood Pressure			
I63.9	Stroke			
J45	Asthma			
J43.9	Emphysema			
J44.1	COPD (Chronic Obstructive Pulmonary Disease)			
D64.9	Anemia			
K76.9	Liver Disease			
K27.3	Stomach or Duodenal Ulcer			
N18.9	Kidney Disease			
M06.80	Rheumatoid Arthritis			
L93	Lupus			
M13.80	Arthritis			
E07.9	Thyroid Disease			
G40.89	Seizures			
I83 / I82.9	Varicose Veins/Blood Clots in Legs			
D69.9	Bleeding Disorder			
B20	AIDS, ARC, or HIV positive test			
F32.8	Depression			
F41.9	Anxiety			
C80.1	Cancer			If yes, explain:
	Other Medical Problems:			

VIDALIA EYE ASSOCIATES **DUBLIN EYE ASSOCIATES**

Medical History Form

SIGN HERE PLEASE! **PATIENT'S NAME:** _____ **DATE:** _____

1. If applicable, are you pregnant? ..... ❑ Yes ❑ No
2. Have you had any previous **EYE surgery** or **injuries**?..... ❑ Yes ❑ No
   If YES, please gives names of operations/injuries and dates:
   _____
3. What **EYE MEDICATIONS** are you currently using? Please give names/dosages:
   _____
   _____
4. What operations have you had (OTHER than on your eyes)? Please gives types/dates:
   _____
   _____
5. Are you a smoker? ..... ❑ Yes ❑ No
   If no, and you smoked in the past, when did you stop? _____
6. Do you drink alcohol? ..... ❑ Yes ❑ No
   If yes, how much? _____
7. Give name/address/telephone # of your personal medical doctor:
   _____
8. Among your **BLOOD RELATIVES**, is there a history of any of the listed problems below?
   Please do NOT include yourself – only your BLOOD RELATIVES
   (use mother, father, sister, brother, grandmother, grandfather, cousin, aunt, uncle, daughter, son)

EYE PROBLEMS		MEDICAL PROBLEMS	
DIAGNOSIS	**FAMILY MEMBER (S)**	**DIAGNOSIS**	**FAMILY MEMBER (S)**
Amblyopia (lazy eye)		Anesthesia Complication	
Angle Closure Glaucoma		Bleeding Disorder	
Astigmatism (light rays are bent)		Brain Tumor	
Cataract (cloudiness of lens)		Cancer	
Choroidal Melanoma		Diabetes	
Corneal Dystrophy		Heart	
Corneal Graft Finding		Hypertension	
Diabetic Retinopathy		Lupus	
High Myopia (nearsighted)		Migraine	
Macular Degeneration		Neurofibromatosis	
Open Angle Glaucoma		Rheumatoid Arthritis	
Retinal Detachment		Stroke	
Strabismus (eye misalignment)		Thyroid Disorder	
Other		Other	

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* Medication Profile *

Patient's Name: _____

Pharmacy & City: _____

Medication Allergies: _____

_____

☐ **No Known Medication Allergies**

Name Of Medication	Dosage (How much do you take and when do you take it?)

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Consents

DUE TO THE HIPPA COMPLIANCE PRIVACY LAWS OF THE FEDERAL GOVERNMENT, IT IS MANDATORY THAT WE ASK YOU TO REVIEW AND ANSWER ALL OF THE FOLLOWING QUESTIONS LISTED BELOW.

HIPPA

1. May we leave messages/detailed medical information on voicemail at either your home phone or cell number(s)?
   ❍Yes ❍No ..... Your Home Phone #: _____
   ❍Yes ❍No ..... Your Cell Phone #: _____
2. May we contact you at your place of employment?..... ❍Yes ❍No If yes, work #: _____
3. Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical, and billing)?
   ❍Yes ❍No If yes, please provide the name/relationship/phone #:_____
4. Is the above person mentioned your Power of Attorney for medical purposes? ..... ❍Yes ❍No
5. Are you interested in having your patient information/records emailed to you?..... ❍Yes ❍No
   Your email address: _____

REFRACTION

REFRACTION SERVICE AND FEE ➲ $ 30.00

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

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.

Our office fee for a refraction is **$30.00** and this fee is collected at the time of service in addition to any co-payment your plan may require. 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 ($30.00) and understand it is due at the time of service. I understand that any co-payment, coinsurance, or deductible I may have are separate from and not included in the Refraction Fee.

SIGN HERE PLEASE! ☞ **Signature:** _____ **Date:** _____

CONSENTS

ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT:

I assign and authorize payment to Vidalia Eye Associates and/or Dublin Eye Associates of all benefits payable under the terms of my insurance policy/policies. I realize that my insurance(s) may not pay my entire bill and I will be responsible for any balance owed to Vidalia Eye Associates and/or Dublin Eye Associates. Should my account become delinquent, I am aware that an outside collection agency may be utilized in order to collect this debt. I agree to reimburse the fees of any collection agency, or attorney firm, which may be based on a percentage at a maximum of 30% of the debt, and all costs and expenses including reasonable attorney's fees incurred in such collection efforts.

CONSENT FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATION:

Vidalia Eye Associates and/or Dublin Eye Associates, as your health care provider, is required to obtain your authorization before any information is released for treatment, payment, or health care operation. This is only to be collected once. You may revoke any authorization in writing at any time. Vidalia Eye Associates and/or Dublin Eye Associates will not use or disclose your medical information for any purpose other than above, without your written authorization.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES:

Our notice of privacy information is about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change and you may obtain a revised copy by contacting our office or by visiting our website **at www.dublineyeassociates.com.**

❖ I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS ❖

SIGN HERE PLEASE! ☞ **PATIENT'S SIGNATURE:** _____ **DATE:** _____

**** THIS AUTHORIZATION IS GOOD FOR 3 YEARS FROM THE DATE SIGNED ****

Revised 01/2018-tsw