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
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, etc.) or injuries (concussion, etc.)
_____

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

PERSONAL MEDICAL HISTORY

Eyes

(CHECK ALL BOXES OF ANY SYMPTOMS 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:

	CONSTITUTIONAL
	Fatigue
	Malaise
	Chills
	Fever
	Night Sweats
	Appetite Changes
	Weight Changes
	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

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

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

	Gastrointestinal
	Diarrhea
	Constipation
	Stool Changes
	Hemorrhoids
	Indigestion
	Difficulty Swallowing
	Nausea/Vomiting
	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:** _____

DEER EYE CLINIC
Philip J. Deer, Jr., M.D.
Philip J. Deer, III, M.D.

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. (A copy can be found at www.Deereyeclinc.com, on the "Patient Forms" page select "Clinic Privacy Practices." A copy can also be requested upon your arrival at Deer Eye Clinic before/on your appointment).

_____ _____
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

Financial Policy

Welcome and thank you for choosing Deer Eye Clinic for your eye care. We are committed to providing you with the highest quality eye care possible in a cost-effective manner.

Our professional fees have been determined through careful consideration in addition to being reasonable and customary within our geographical area. We are pleased to discuss with you any question you may have concerning a bill.

Payment in full is due at the time services are rendered. Our staff check your insurance benefits and take that information into consideration when collecting for the appointment. As a courtesy to our patients, we accept cash, personal check, money order, Visa, MasterCard, Discover, American Express, and Care Credit.

In order to achieve our goal of providing you with the best care possible, we need your assistance and your understanding of our financial policy:

Cancellation and Missed Appointment Policy:

- When a patient is late for their appointment this can cause us to get behind on our schedule which can affect other patient's visits. Our policy is that if a patient is more than 15 minutes late for their appointment, the patient may be asked to reschedule their appointment, depending on the day's schedule.
- 24 hours' notice is required to cancel and/or reschedule all appointments. Failure to do so will result in a $30.00 fee.

Refraction Service Fee:

- The refraction test is the process to determine 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.
- 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. Most medical insurance plans, including Medicare, do not cover routine refractions or routine eye exams.

Additional paperwork:

- Any paperwork from another institution needed to be filled out by the physician will result in an additional charge, depending on the length of the paperwork.
- A 48-hour notice is required for all paperwork or records request.

Auto accidents/workers compensation:

- Motor Vehicle Accidents (MVAs) will be filed to your auto insurance as a courtesy to you. Failure to receive payment within 30 days of the date of service may result in you becoming responsible to pay.
- Our office will send appropriate workers compensation claim forms for services rendered on your behalf as a courtesy. If a claim is denied, we will expect payment in full from you within 30 days of receipt of our bill.

Collections and outstanding balances:

- Any outstanding balance after 60 days of the date of service will be referred to an outside collection agency. Accounts referred to an outside collection agency will be subject to a collection fee of 40%, which will be added to the total balance due at the time of write off.

Refunds:

- Refunds are issued to the appropriate party.
- Patients refunds will not be processed until all active or past due charges are paid in full.
- Refunds less than $10.00 will not be issued, unless requested, and will credit to your account at our practice.

Returned Check Fee:

- There will be a fee of $25.00 for any returned checks to our office.

All balances are due prior to any further service provided by our office.

Signing Below Acknowledges that You have Read and Understand the Above Stated Policies.

_____ _____

Signature of Patient or Patient Representative Date