1720A Medical Park Drive, #330
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

## PATIENT INFORMATION
**(Please Print)**

| Patient Name | | Social Security Number | |
|---|---|---|---|
| Date of Birth | | Sex | |

**Address:**_________________________________________ **Apt #** _______________
**City:**___________________________ **State:** _________ **Zip Code** _______________
**Home Phone:** ____________________ **Cell Phone:** ______________________
**Email:** _______________________________________ **Martial Status**__________
**Your *Primary Medical* Doctor**___________________ Referring Doctor_______________
**Person(s) we can discuss and or release your health information to: Self only** ___
**Name(s)**____________________________________________________________________
**Responsible Party (Name: Self, Spouse or Parent/Guardian)**
**Name:**____________________ SS# ______________Date of Birth ____________
Address __________________________ City ______________ State ______ Zip _________
Place of Employment (Self or Parent) ______________________Phone #_________________
Occupation (Patient) :____________________________________________________________
Place of Employment (Spouse)____________________________Phone #_________________

## Insurance Information:

Primary Insurance. ___________________**Policy #** _________________________
Group # ____________________ Relationship to Patient:__________________
Insured Date of Birth:___/___/_____ SSN:_____________________
**Vision Insurance** _________________ Policy # ___________________________

**Secondary Insurance Company**: _______________ **Policy#**______________________________
Group # ______________ Insured Name on Card:___________
Insured Date of Birth:___/___/_____ Relationship to Patient:_______________________

**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 insurance carrier, if applicable. I understand I am financially responsible for any balance not paid by my insurance. I understand that if my account goes to an outside collections agency there is a $25.00 charge added to my balance. We understand that occasionally missed appointments occur for various reasons. A "No-show" is defined as missing an appointment without canceling at least 24 hours before the scheduled time. There will be a $25.00 charge for a missed or non-canceled appointment. Insurance will not cover these fees. I acknowledge that I have received a copy of Eye Associates of the South privacy notice. I understand that I am responsible to read this notice and notify Eye Associates of the South, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. Eye Associates of the South has the right to revise this notice at any time and will always post a copy of the current notice in the office in a visible location. Eye Associates will provide me with a copy of its most recent notice upon my request.**

_______________________________________________________________________________
**Patient Signature** **Date**

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**Name:**_________________________________ **DOB** _____________

**PAST MEDICAL HISTORY: (PLEASE CHECK ALL THAT APPLY OR "NONE" IF NONE APPLY)**

☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial fibrillation
☐ BPH
☐ Breast Cancer
☐ Colon Cancer
☐ COPD
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ GERD
☐ Hearing Loss
☐ Hepatitis
☐ Hypertension
☐ HIV/AIDS
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Prostate Cancer
☐ Radiation Treatment
☐ Seizures
☐ Stroke
☐ **NONE**
**Other**_________________________
_________________________
_________________________

**PAST SURGICAL HISTORY: (PLEASE CHECK ALL THAT APPLY OR "NONE" IF NONE APPLY)**

☐ Appendix Removed
☐ Breast Biopsy (Right, Left, Both)
☐ Lumpectomy (Right, Left, Both)
☐ Mastectomy (Right, Left, Both)
☐ Colectomy: Colon CA Resection
☐ Colectomy: Diverticulitis
☐ Colectomy: IBD
☐ Gallbladder Removed
☐ Heart: Coronary Artery Bypass
☐ Joint Replacement, Hip
☐ Joint Replacement, Knee
☐ Ovaries Removed: Endometriosis
☐ Ovaries Removed: Ovarian CA
☐ Ovaries Removed: Ovarian Cyst
☐ Prostate Removed: Prostate CA
☐ Prostate: TURP
☐ Skin: Basal Cell Cancer Surgery
☐ Skin: Melanoma
☐ Skin: Skin Biopsy
☐ Skin: Squamous Cell Carcinoma
☐ Uterus: Fibroids
☐ Uterus: Uterine Cancer
☐ Uterus: Cervical Cancer
**Other**_________________________
_________________________
_________________________
☐ **NONE**

**PEDIATRIC HISTORY (FOR DR. EUSTIS PATIENTTS ONLY)**

| Gestational Age at birth | Weeks | Birth Weight | lbs oz |
|---|---|---|---|
| Maternal Illnesses during pregnancy | | Forceps Delivery | ☐ YES ☐ NO |

**OCULAR HISTORY: (PLEASE CHECK ALL THAT APPLY OR "NONE" IF NONE APPLY)**

☐ Allergic Conjunctivitis
☐ Blepharitis
☐ Cataract ( ☐Left ☐Right)
☐ Corneal Dystrophy
☐ Diabetic Retinopathy
☐ Dry Eyes
☐ Glaucoma
☐ LASIK (☐ Left ☐ Right)
☐ Macular degeneration
☐ Macular ERM (☐ Left ☐ Right)
☐ Narrow angle (☐ Left ☐ Right)
☐ Ocular HTN (☐ Left ☐ Right)
☐ Retinal tear (☐ Left ☐ Right)
☐ Strabismus
☐ PVD / Floaters (☐·Left ☐ Right)
**Other**_________________________
_________________________
_________________________
☐ **NONE**

**OCULAR SURGERY : (PLEASE CHECK ALL THAT APPLY OR "NONE" IF NONE APPLY)**

☐ Cataract (Left eye, Right eye)
☐ Glaucoma (Left eye, Right eye)
☐ Retinal tear (Left eye, Right eye)
☐ Strabismus
☐ Punctal Plugs
☐ Blepharoplasty
☐ LASIK (☐ Left ☐ Right)
☐ Ptosis
☐ DCR
☐ YAG capsulotomy
(☐ Left ☐ Right)
**Other**_________________________
_________________________
_________________________
☐ **NONE**

EYE ASSOCIATES OF THE SOUTH

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**Name:**_________________________________________**DOB:**________________

**SOCIAL AND FAMILY (PLEASE CHECK ALL THAT APPLY OR "NONE" IF NONE APPLY**

**Social History**

☐ Never smoked
☐ Smoker - Former
☐ Smoker - Current

Alcohol Consumption

☐ **None**
☐ Less than 1 drink per day
☐ 1-2 drinks per day
☐ More than 3 drinks per day

**Family History**

☐ Diabetes
☐ Hypertension
☐ Glaucoma
☐ Cancer
☐ None

☐ Patient feels safe at home

☐ Patient feels unsafe at home

| Preferred Pharmacy | | City | State |
|---|---|---|---|

Do you take any *pills*? Or eye ***drops or ointments***?

| Name of Medicine | *Dose* | *For what condition* | How often |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Do you have *ALLERGIES* to any medicines?**

| Name of Medicine | Name of Medicine |
|---|---|
| 1. | 4. |
| 2. | 5. |

**Additional items required of patients at the time of the visit include:**

- **Photo ID**
- **Insurance Card(s)**
- **Current Glasses and or Contact Lens Information**

Patient Signature Doctor Signature Date