McClanahan
Eye Care

130 Hospital Dr., Winchester, KY 40391
859-737-5599

DATE: ____/____/____

NAME: ____ AGE:__________DOB:___/____/_____

ADDRESS: ________________________________CITY: _______________ STATE: ___ ZIP: ______

HOME PHONE: _______________________ CELL PHONE: ___________________________

Email Address _________________________________Marital Status: Single Married Divorced Widow

GENDER: M F T SSN:_________________________ Race/Ethnicity: White Black Asian Hispanic American Indian Other_____

NAME OF PRIMARY (the person who carries the insurance)
INSURED:____________________________________DOB_____________SSN___________________

Primary Care
Physcian____ADDRESS_____________________________
Endocrinologist if Diabetic
Physcian____ADDRESS_____________________________

Pharmacy Used ___________________________________ADDRESSS____________________________

EMERGENCY CONTACT: _________________________RELATIONSHIP:____________PHONE_________

MEDICAL HISTORY

Date of last eye exam____________Where was exam____

Do you currently wear Glasses? Yes No Do you currently wear Contacts? Yes No
If Yes, how long have you worn your current prescription?_________

List any Medications you are currently taking (prescription and over-the-counter)

____

____

____

Do you have any **allergies** to medications? Yes No If yes, please list_______________________
Latex Allergy? Yes No Have you ever had a blood transfusion? YES NO

List any **surgeries** you have had: cataract lasik tonsillectomy appendectomy heart Other
____**None**_____

List **major illnesses**: glaucoma diabetes I diabetes II high blood pressure heart attack stroke cancer Rheumatoid arthritis Lupus Multiple Sclerosis HIV Other______________**None**______

Are you currently pregnant? Yes No If yes, how many months___________

For OFFICE USE ONLY
Patient information verified by staff member ____Date_________________

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Please mark yes or no for all of the following eye health problems. If yes, please provide date symptoms began

Loss of vision	YES _________	NO	Foreign body sensation	YES _________	NO	
Blurred vision	YES _________	NO	Excess tearing/watering	YES _________	NO	
Distorted vision	YES _________	NO	Glare/light sensitivity	YES _________	NO	
Loss of side vision	YES _________	NO	Eye pain or soreness	YES _________	NO	
Double vision	YES _________	NO	Tired Eyes	YES _________	NO	
Fluctuating vision	YES _________	NO	Crossed or lazy eyes	YES _________	NO	
Dryness	YES _________	NO	Redness	YES _________	NO	
Itching	YES _________	NO	Drooping eyelid	YES _________	NO	
Burning	YES _________	NO	Mucous discharge	YES _________	NO	
Sandy/gritty feeling	YES _________	NO	Infection of eye or lid	YES _________	NO	Other______________

Please check any following general health conditions and give date condition began or check none.

GENERAL/CONSTITUTIONAL	Fever ______________Weight Loss _____________ Other ___________________________
EARS NOSE THROAT	Sinus ______________Ear Infection ___________ Chronic Cough_________Other ______
CARDIOVASCULAR	Heart________________Vessels___________Other____________________________________
RESPIRATORY	Asthma________Emphysema___________COPD____________Other___________________
GASTROINTESTINAL	Stomach ulcers_________________Intestinal Disease______________Other______________
GENITAL, KIDNEY, BLADDER	____
MUSCLES, BONES, JOINTS	Arthritis____________________________Other____
SKIN	Acne__________Warts__________Skin Cancer_____________Other____________________
NEUROLOGICAL	Multiple Sclerosis_____________________Other_____________________________________
PSYCHIATRIC	Anxiety_________Depression___________Insomnia__________Other___________________
ENDOCRINE	Diabetes________ Hyperthroidism_________Other___________________________________
BLOOD/LYMPH	Anemia_________Cholesterolemia_________Other___________________________________
ALLERGIC/IMMUNOLOGIC	Hayfever________Lupus__________Sjogrens____________Other_______________________

None of the above_________

Please mark anyone in your immediate family who has any of the following conditions or check None

Glaucoma	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle
Blindness	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle
Cataracts	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle
Cancer	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle
Diabetes	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle
Heart Disease	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle
High blood pressure	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle
Kidney disease	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle
Lupus	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle
Macular Degeneration	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle
Stroke	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle
Thyroid disease	Mom	Dad	Sibling	Grandmother	Grandfather	Aunt	Uncle

None of the above________ **Family History Unknown__________**

SOCIAL HISTORY

Please circle YES or NO for the following questions.

Current Occupation: ____________________________________ Education: Grade school High school Vocational school College

Do you live alone? YES NO Do you drive? YES NO Do you have problems with night vision YES NO

Do you drink alcohol? YES NO If Yes: Occasional 1/day 2-3/day 4 or more/day
Do you smoke? YES NO If Yes: Occasional ½ pack/day 1 pack/day 1 or more packs/day

Office Use ONLY---------------------------
Physician's Signature____________________ History reviewed_________Additions as noted above________________________ Date____________
Physician's Signature____________________ History reviewed_________Additions as noted above________________________ Date____________
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Patient's Financial Responsibility

Descriptions and verification of benefits and eligibility by an insurance company are not a guarantee of payment.
I understand that I am responsible for any amount not covered by my insurance.

I understand that McClanahan Eye Care is filing my insurance as a courtesy and that the description of benefits and eligibility provided to them by my insurance is NOT A GUARANTEE OF PAYMENT. **If for any reason, my claim is denied, I am responsible for payment** of all charges to McClanahan Eye Care for professional, medical and material charges immediately upon request. McClanahan Eye Care is not responsible for how long a claim takes to process.

I further acknowledge that I am responsible for all copays, deductibles, coinsurance and additional charges over and above my insurance for this and all future visits.

I agree to provide all current insurance information and cards at each visit and understand that if this information is incorrect or not presented by me at my visit, it will be my responsibility to pay all charges in full, at the time of service, and I will be responsible for filing my claim. I understand that by doing so, the claim may be paid as "out of network benefits" by my insurance company and McClanahan Eye Care will not reimburse me for any amounts paid by me over what my insurance reimburses me.

McClanahan Eye Care's Payment/Return policies are as follows:

- **We require payment in full at the time of service**. We accept all major credit/debit cards, cash or check as payment.
- **We charge a service fee of $5.00 per month on all unpaid balances over 30 days old. We charge $50 for all returned checks.** Patient/customer is responsible for all court costs, attorney/collection fees incurred to collect any outstanding balances.
- There is no refund on any exam services/tests provided by our staff.
- 70% refund on all patient paid portions of glasses and contact lenses within 30 days of purchase. Glasses must be in the same condition as sold. Contacts must be in unopened, unmarked boxes.

HIPAA-Health Insurance Portability and Accountability Act

McClanahan Eye Care complies with all HIPAA regulations – your medical and personal information is confidential. A copy of the complete privacy policy is available at the front desk. By signing below, I acknowledge that a copy of the HIPAA policy has been made available to me.

By signing below, I am indicating that I have read, fully understand and agree to abide by these policies.

____Date__________ ____________________________
Signature of Patient/Insured or Parent/Guardian Witness

☐**Sharing and/or Releasing My Medical Information**

If you would like McClanahan Eye Care to be able to discuss your medical records and/or ledger information with a spouse or other family member, **please let us know so you can sign our HIPAA Compliant Release form**. Without it we will not be able to speak to anyone who calls other than yourself.

☐**DO NOT Share My Medical Information**

By signing below, I acknowledge that I was given the opportunity to sign a shared release of my medical and ledger information for a spouse or family member but **do not want anyone other than myself to have this information**.

____ Date__________
Signature of Patient/Insured or Parent/Guardian

Authorization Release To Pay Benefits To Physician

I hereby authorize release of any medical information necessary to process this claim and all future claims. I further request that payment of assigned benefits be made to Dr. McClanahan/McClanahan Eye Care. **I understand that I am financially responsible for all charges whether, not paid or denied by said insurance** A copy of this statement shall remain on file and in force until revoked by me in writing.

PATIENT NAME
Please Print____DOB_________If under 18 Guardian Name____________________________________

Signature____Date________ Signature____Date_______

Signature____Date________ Signature____Date_______

Signature____Date________ Signature____Date_______

Signature____Date________ Signature____Date_______

Signature____Date________ Signature____Date_______

Signature____Date________ Signature____Date_______

Signature____Date________ Signature____Date_______

Shared Release

McClanahan Eye Care

130 Hospital Drive 859-737-5599
Winchester, KY 40391 859-737-0650 fax

HIPAA Compliant Form to Release Patient Information

Patient Name:____ **DOB:**________________

Patient Phone Number:_____________________________

I authorize the release of my information and/or medical records from:

McClanahan Eye Care

130 Hospital Dr., Winchester, KY 40391, Ph: 859-737-5599, Fax: 859-737-0650

Information to be released to **Family member and/or Physician/Clinic** listed below:

___All medical records

OR if only specific records please select which information you want shared:

___Test results ___Consultation report ___History & Physical exam

___Glasses and/or Contact lens prescription ___Billing information ___Other:_______________________________

Information is to be released for the purpose of:

___At my request ___Continuing Care ___Changing Providers ___Second Opinion

I authorize the release of this information to:

Family Member____ Relationship_______________

Family Member____ Relationship_______________

Physician/Clinic____

Address:____ Phone____________________

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization.

This authorization will expire one year from the date of signing, unless revoked earlier.

Specific Expiration date if requested for less than 1 year______________________________.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

Patient/Legal Guardian Signature:________________________________ Date:_________________

*If Legal Guardian, PRINT name and Relationship to Patient*____

Office Witness Signature____ Date:_____________________