PATIENT INFORMATION

PHYSICIANS NO._____ ☐ NEW

F.P.C._____ ☐ CHANGE

STATUS_____ ACCOUNT NUMBER_____

1. PATIENT'S FULL NAME_____ TELEPHONE #_____

RESPONSIBLE PARTY FULL NAME_____ TELEPHONE #_____

RESPONSIBLE PARTY ADDRESS (STREET)_____ APT. #_____

(CITY)_____ (STATE)_____ (ZIP)_____ (COUNTY)_____

PATIENT'S BIRTHDATE_____ AGE____ SOCIAL SECURITY #_____ RACE_____

IS PATIENT A DEPENDENT CHILD? ☐ YES ☐ NO SEX_____

IN CASE OF EMERGENCY CONTACT_____ PHONE_____

PATIENT REFERRED BY_____

MARITAL STATUS (☐ SINGLE (☐ MARRIED (☐ WIDOWED (☐ DIVORCED

RESPONSIBLE PARTY EMPLOYER'S NAME & ADD._____ TELE. #_____

SPOUSES'S EMPLOYER'S NAME & ADD._____ TELE. #_____

DATE OF ACCIDENT_____

HOW DID ACCIDENT OR INJURY OCCUR?_____

HAVE YOU EVER HAD ANY PREVIOUS SERIOUS ILLNESS?_____

ARE YOU NOW TAKING ANY TYPE OF MEDICATION?_____

HAVE YOU EVER HAD ANY PREVIOUS SURGERY?_____

DO YOU HAVE ANY DRUG ALLERGIES THAT YOU ARE AWARE OF?_____

HAVE YOU EVER HAD THE SAME OR SIMILAR CONDITON AND WHEN?_____

I AGREE TO PAY ALL BILLS UPON RECEIPT OF STATEMENT OR AS OTHERWISE AGREED.

DATE_____ SIGNATURE_____

2. **INSURANCE** ☐ ☐

MEDICARE	MEDICARE/WELFARE	WELFARE	CLAIM NUMBER	CASE NUMBER
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO		

☐ **PRIVATE OR GROUP INSURANCE**

	PRIMARY	SECONDARY
INSURANCE CO. NAME		
INSURANCE CO. ADDRESS		

PATIENT INFORMATION SHEET

Name:_____Age____ Birth Date:_____ Sex:____M____F

Mailing Address:_____ SS#__ __ __-__ __-__ __ __ __

City/State:_____ Zip_____

Home Phone#: (____) _____ Work Phone#: (____) _____ Cell Phone#: (____)_____

Appointment Reminder Call Contact # (please circle one): Home Work Cell Other: (____) _____

Name of Employer:_____Occupation:_____

Please list anyone we may release medical information to:_____

Is the patient under Hospice Care? ____YES ____NO

IF PATIENT IS A MINOR:

Mother's Name:_____ Birth Date:_____

SS#__ __ __-__ __-__ __ __ __ Address:_____

Phone#: (____) _____ Employer:_____

Employer's Address:_____

Father's Name:_____ Birth Date:_____

SS#__ __ __-__ __-__ __ __ __ Address:_____

Phone#: (____) _____ Employer:_____

Employer's Address:_____

Power of Attorney:

Name:_____ Phone#: (____)_____

Mailing Address:_____

City/State:_____ Zip_____ Relationship to Patient:_____

Primary Insurance Information:

Insurance Company:_____ Cardholder Name:_____

Member ID#_____ Group#_____

Birth Date:_____ Relationship to Patient_____

Secondary Insurance Information:

Insurance Company:_____ Cardholder Name:_____

Member ID#_____ Group#_____

Birth Date:_____ Relationship to Patient_____

Consent to Payment

I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if Enid Eye, Inc. does not participate with my insurance. I agree to pay all co-payments, coinsurance, and deductibles at the time services are rendered. **Initial:**_____

I authorize the release of any medical information necessary to process this claim and all future claims. I also authorize payment of medical benefits directly to my physician. I certify the information provided is true and correct. **Initial:**_____

Privacy Practice

I acknowledge that I have been provided access to Enid Eye, Inc. Notice of Privacy Practices (HIPPA) effective 9-23-13. I acknowledge that I can obtain a copy of the full HIPPA from the front office. If I have any questions regarding the HIPPA, I will ask to speak with the privacy officer. **Initial:**_____

I consent to have photographs taken, if necessary for medical treatment. **Initial:**_____

_____ _____

Signature of Patient or Patient's Representative **Date**

Medical History

Name_____ **Age**____ **Birthdate**_____

Home Phone_____ **Cell Phone**_____

Emergency Contact_____ **Phone**_____

Primary Care Physician_____ **Phone**_____

Place a check by any medical conditions that you have:

Diabetes..... ☐ Cancer..... ☐
Arthritis..... ☐ High blood pressure ☐
Other_____

Place a check by any eye disease that you have:

Glaucoma.... ☐ Cataracts..... ☐ Macular degeneration.....☐
Lazy eye..... ☐ Retinal detachment ☐
Other_____

Do any medical or eye diseases run in your family? (diabetes, high blood pressure, cancer, glaucoma, or macular degeneration). If yes, please explain_____

Why are we seeing you today?_____

List of Medications:_____

_____

Drug Allergies:_____

Previous Surgeries:_____

Have you had any of the following problems:

Chronic fever, unexpected weight loss/gain, or fatigue_____
Ear/Nose/Throat problems(hearing loss, sinus trouble)_____
Heart problems(chest pain, irregular heartbeat)_____
Respiratory problems(asthma, bronchitis, wheezing)_____
Gastrointestinal problems(heartburn, abdominal pain, diarrhea)_____
Urinary problems(pain/discomfort, bladder infections, prostate)_____
Skin disease (dermatitis, eczema, rashes)_____
Musculoskeletal problems(arthritis, muscle aches, swollen joints)_____
Neurological problems(numbness, weakness, paralysis, headache)_____
Psychiatric problems (depression, anxiety)_____

Do you smoke? Yes or No - If yes, how much?_____ **Do you drive? Yes or No**
Do you drink? Yes or No - If yes, how much?_____

_____ _____
Physician's Signature **Date**