Wilkes Eye Center

Patient Information

TODAY'S DATE _____/____/_____

NAME:_____ SEX____(M)_____(F)
LAST FIRST MIDDLE

MARITAL STATUS:____SINGLE____MARRIED____WIDOWED____SEPERATED

_____ _____
NAME BY WHICH YOU ARE CALLED IF CHILD/PARENT'S NAME

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

EMAIL ADDRESS:_____ CELL PHONE:(___)_____ _____

MAY WE TEXT YOU APPOINTMENT REMINDERS YES_____ NO_____

HOME PHONE:(___)____ _____ WORK PHONE:(___) _____ _____

BIRTH DATE:_____/_____/_____ AGE:_____ SOCIAL SECURITY NO.____-____-_____

EMERGENCY CONTACT:_____

RELATIONSHIP TO PATIENT:_____ PHONE:(___)____-_____

PRIMARY CARE PHISICIAN:_____ PHONE:(___)____-_____ FAX(___)___-____

DOCTOR'S ADDRESS:_____

PHARMACY:_____ PHARMACY PHONE# (___)____-_____

_____ **INITIAL HERE ****NO SHOW POLICY : (PLEASE INITIAL TO CONFIRM THAT YOU HAVE READ THIS POLICY). IF I MISS AN APPOINTMENT, WITHOUT CALLING TO CANCEL AT LEAST 24 HOURS IN ADVANCE, I AGREE TO PAY THE REQUIRED $25.00 NO SHOW FEE.**

_____ **INITINAL HERE ****WE FILE YOUR INSURANCE AS A COURTESY TO YOU, PLEASE NOTE THAT ANY AMOUNT NOT PAID BY YOUR INSURANCE COMPANY IS ALWAYS THE PATIENT'S RESPONSIBILITY.**

PREFERED LANGUAGE

_____

ETHNICITY
NOT HISPANIC OR LATINO
OR HISPANIC OR LATINO

RACE

_____

HEIGHT _____ WEIGHT_____

SMOKING STATUS
CURRENT EVERYDAY SMOKER
NEVER SMOKED
FORMER SMOKER

WHO REFERED YOU TO WILKES EYE CENTER?_____

Practice Name _____
Address _____
City, State, Zip _____
Phone _____

Date _____
Patient _____
ID#: _____
Group#: _____

I, _____, understand that services rendered to me by WILKES EYE CARE/ CENTER are my financial responsibility and that the Provider will bill my insurance company, _____as a courtesy. I authorize my insurance company to pay my benefits directly to WILKES EYE CARE/ CENTER and I understand that I will be fully responsible for any outstanding balance on my account.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by _____.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information above and beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to WILKES EYE CARE/ CENTER within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize WILKES EYE CARE/ CENTER to facilitate payment utilizing the credit card number on file to resolve the balance.

I authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

_____
Signature of Policyholder

_____
Patient /Guardian Printed Name

Wilkes Eye Center
Patient Consent For Use and Disclosure
Of Protected Health Information

I hereby give my consent for Wilkes Eye Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Wilkes Eye Center's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Wilkes Eye Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Wilkes Eye Center HIPPA Coordinator at 23 East Square, Washington, GA 30673.

With this consent, Wilkes Eye Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care including laboratory results among others.

With this consent, Wilkes Eye Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Wilkes Eye Center may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Wilkes Eye Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Wilkes Eye Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it , Wilkes Eye Center may decline to provide treatment to me.

I permit Wilkes Eye Center to release my PHI to : _____

_____
Relationship (Ex: spouse, parent, child, etc.)

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Patient's Name Print Name of Patient or Legal Guardian

Wilkes Eye Center Patient Information Form

Date:_____ **Gender/Age:**_____**Parent/Guardian**_____

Past Medical History:

Heart Disease (heart attack, pacemaker, valve problems, irregular heart beat, heart failure)? YES / NO
Chronic skin disease (rosacea, stevens-johnson, acne)? YES / NO Stroke? YES/NO
Breathing difficulties (COPD, sleep apnea)? YES / NO Hepatitis (A,B,C)? YES/NO

Diabetes?	YES/NO	High Cholesterol?	YES/NO	Seizures/Epilepsy?	YES/NO
High blood pressure?	YES/NO	Aids/HIV?	YES/NO	Dementia?	YES/NO
Cancer?	YES/NO	Anemia?	YES/NO	Pituitary Disorder?	YES/NO
Tuberculosis?	YES/NO	Brain Tumor?	YES/NO	Jorgen's Syndrome?	YES/NO
Bleeding Disorder?	YES/NO	Multiple Sclerosis?	YES/NO	Syphilis/ Gonorrhea?	YES/NO
Kidney/liver disease?	YES/NO	Mental Illness?	YES/NO	Herpes, Chlamydia?	YES/NO
Myasthenia Gravis?	YES/NO	Lupus?	YES/NO	Headaches/migraines?	YES/NO
Sinus disease?	YES/NO	Allergies/Asthma	YES/NO	Thyroid disease?	YES/NO

Other?
Explain: _____

_____

Operations: (include radiation/chemotherapy/date) _____

_____

Females only: Are you currently or possibly pregnant? YES/NO Expected delivery date?__/____/___ Nursing? YES/NO

****

POST OCULAR HISTORY: (Circle and explain or circle none)

Have you been diagnosed with: Glaucoma? YES/NO Macular degeneration? YES/NO Lazy/Crossed Eye? YES/NO
Dry eyes? YES/NO Retinal detachment/tear? YES/NO Color Blindness? YES/NO Blindness? YES/NO

_____

Previous eye or lid surgery and year? _____
Contact lens use? YES/NO _____hrs per day Soft or Gas Perm Age of current glasses/contacts?_____

****

FAMILY HISTORY: List family relationship & age of family members with any of the following or circle none: NONE

Eye lid droop? Retinal Detachment? Crossed or lazy eye? Blindness?
Night or color blindness? Glaucoma? Macular Degeneration?
Heart Disease? Stroke? MS? Neurological disease? Cancer/Tumors?
Autoimune Disease? Diabetes? Thyroid disease? Bleeding Disorders?
Kidney/lung/liver disease? High cholesterol? Muscular disease? Tuberculosis?
Allergies? Hay fever? Asthma? Rashes? Syphilis?

****

SOCIAL HISTORY: Circle one or fill-in-the answers NONE

Smoker? YES/NO Alcohol use? YES/NO (Rare, socially or daily) Illicit drug use? YES/NO
Sexually active? YES/NO Sexual Partner? Male/ Female
Recent Foreign travel?_____ Special Dietary Preference?_____ Pets?_____ Camping?_____

****

MEDICATIONS: List all prescription medications you are taking or none: NONE

_____

_____

Over the counter medications: _____ NONE
List all eye drops:_____
Aspirin or bloodthinners_____ NONE
Have you taken Accutane (isotretinoin) in the last 6 months? YES/NO
DRUG ALLERGIES _____ NONE

Patient Signature: _____ Date: _____