

Dear Patient:

We welcome you to Southeast Eye Clinic. Thank you for choosing our clinic. Our caring physicians and staff are here to provide you with the best in comprehensive, medical and surgical eye care.

The enclosed patient information allows us to begin this process. Please complete this paperwork and bring it with you on the day of your appointment or fax to 702-7819, along with a list of all your current medications and insurance information.

If you have any questions or concerns during any part of your care, please notify me personally at 794-1968 or ask for me while in the clinic. Your eyesight is our top priority! Our goal is to provide you with the finest physicians, facility and staff that you feel comfortable with and recommend to others. We look forward to SEEing you soon!

Sincerely,

Cheri Kelly-Sherer  
Administrator

CKS/sg

# WELCOME TO SOUTHEAST EYE CLINIC

Date: \_\_\_\_\_

## How did you hear about us?

Referred By: Dr. \_\_\_\_\_ Radio \_\_\_\_\_  
My friend \_\_\_\_\_ Billboard \_\_\_\_\_  
Emergency \_\_\_\_\_ T.V. \_\_\_\_\_  
Former Patient \_\_\_\_\_ Yellow Pages \_\_\_\_\_  
Newspaper \_\_\_\_\_ Other \_\_\_\_\_

## Patient Information

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip Code

Telephone (Home) \_\_\_\_\_ Social Security # \_\_\_\_\_ Sex: Male / Female

(Work) \_\_\_\_\_ Employment Status: Full-Time / Part-Time / Retired / Not Employed

(Email) \_\_\_\_\_ Initial if you prefer to opt out of e-mail contact \_\_\_\_\_

Employer \_\_\_\_\_ Employer Address \_\_\_\_\_  
Name Street City State Zip Code

Notify in an Emergency \_\_\_\_\_  
(Other than someone at your residence) Name Relationship Telephone (Home) (Work)

## Spouse Information

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ Spouse's Social Security # \_\_\_\_\_

Telephone (Work) \_\_\_\_\_ Spouse's Birthdate \_\_\_\_\_ Retirement Date \_\_\_\_\_

## If Patient is Under 21

Parent or Legal  
Guardian's Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

Social Security # \_\_\_\_\_ Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Employment Status: (Full-Time / Part-Time / Retired / Not Employed) Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

## Insurance Information

\_\_\_\_\_ Blue Cross / Blue Shield \_\_\_\_\_ Tricare \_\_\_\_\_ Medicare \_\_\_\_\_ Medicaid \_\_\_\_\_ Other / HMO  
\_\_\_\_\_ Standard \_\_\_\_\_ Alabama  
\_\_\_\_\_ Prime \_\_\_\_\_ Florida  
\_\_\_\_\_ Georgia

# SOUTHEAST EYE CLINIC

## PATIENT INFORMATION

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_

### *Personal & Medical History*

Who is your primary physician? \_\_\_\_\_  
Name City State

Do you wear glasses?  Yes  No If so, how long? \_\_\_\_\_

Do you wear contact lenses?  Yes  No If so, how long? \_\_\_\_\_

Do you smoke or use tobacco products?  Yes  No If so, how long? \_\_\_\_\_

Do you use drugs?  Yes  No If so, how long? \_\_\_\_\_

Do you use alcohol?  Yes  No If so, how long? \_\_\_\_\_

Are you pregnant?  Yes  No If so, how many weeks? \_\_\_\_\_

Have you ever had eye surgery?  Yes  No

If yes, please describe: \_\_\_\_\_

Have you ever had an eye injury?  Yes  No

If yes, please describe: \_\_\_\_\_

Do you live:  Alone /  Family /  Friend /  Nursing Home Do you currently drive?  Yes  No

Do you have any hobbies? If so, what? \_\_\_\_\_

### *List all Medications & Dosage*


Are you allergic to any medications? \_\_\_\_\_

Past Surgical Procedures: \_\_\_\_\_

Circle if you currently have any problems in the following areas:

- |             |                    |  |                    |            |                    |
|-------------|--------------------|--|--------------------|------------|--------------------|
| Fever       | Sinus Congestion   | Heart / Pacemaker / Defibrillator / Artificial Heart Valve |                    |            |                    |
| Weight Loss | Post-Nasal Drip    | High Blood Pressure  | Lung               | Diabetes   | Bladder            |
| Muscles     | Chronic Cough      | Artery Disease   | Breathing          | Stomach    | Bleeding Disorders |
| Joints      | Dry Throat / Mouth | Stroke   | Asthma             | Intestines |                    |
| Arthritis   | Skin               | Migraines  | Chronic Bronchitis | Genitals   |                    |
| Cancer      | Allergy Symptoms   | HIV / AIDS   | Thyroid            | Kidneys    |                    |

### *Family Health History*

Have any of your blood relatives ever had the following? (Mother, Father, Brother, Sister) M-F-B-S

- |                              |                                    |                                     |
|------------------------------|------------------------------------|-------------------------------------|
| <u>M-F-B-S</u> Heart Disease | <u>M-F-B-S</u> Blindness           | <u>M-F-B-S</u> Macular Degeneration |
| <u>M-F-B-S</u> Glaucoma      | <u>M-F-B-S</u> Retinal Detachment  | <u>M-F-B-S</u> Diabetes             |
| <u>M-F-B-S</u> Stroke        | <u>M-F-B-S</u> High Cholesterol    | <u>M-F-B-S</u> Arthritis            |
| <u>M-F-B-S</u> Cancer        | <u>M-F-B-S</u> High Blood Pressure | <u>M-F-B-S</u> Thyroid Disease      |

Other (please list): \_\_\_\_\_

I hereby authorize Southeast Eye Clinic to release my medical information to any physician or medical facility that I may be referred to by Southeast Eye Clinic. I also authorize Southeast Eye Clinic to furnish medical information to any insurance company or any insurance carriers or to the Social Security Administration and Health Care Financing Administration or its intermediaries and any information needed for Medicare claims or any other insurance carrier(s). I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignments. Regulations pertaining to Medicare assignments of benefits apply.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby authorize payment of my medical and surgical insurance benefits to Southeast Eye Clinic. I am financially responsible for any charges whether or not paid by said insurance. If my insurance company or health plan designates co-payment and / or deductibles, I agree to pay them to Southeast Eye Clinic. I authorize Southeast Eye Clinic to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

The undersigned accepts the fee for charges as a lawful debt and promises to pay said fees including costs of collection, attorney fees and court costs, if such should be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other State. Further, I agree to the following terms regarding any outstanding balance that I owe:

- (1) I will incur interest at the rate of 1.5% per month (18% per annum).
- (2) Any lawsuit and / or legal proceeding surrounding the outstanding balance and debt shall be initiated and litigating in the court of appropriate jurisdiction of Houston County, Alabama, and hereby waive any and all defenses and / or objections to said jurisdiction. By signing below, I consent to the terms contained herein and affirmatively acknowledge that I have read the same before signing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **Patient Consent Form (Privacy, Payment & Treatment)**

Southeast Eye Clinic's notice of privacy practices provides information about how we may use and disclose protected health information. You have the right to review the Notice of Privacy Practices before signing this document. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by request at the front desk.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure by our staff and business associates of protected health information about you for treatment, payment and health care operations of the practice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

### **LIST ANY RESTRICTIONS ON RELEASE OF INFORMATION:**

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Restrictions Reviewed By: \_\_\_\_\_

Chart & System Notated: \_\_\_\_\_

Date: \_\_\_\_\_

Agreed & Acknowledged / Patient Signature or Personal Representative:

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Name of Patient or Personal Representative:

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Relationship to Patient: \_\_\_\_\_

Source of Authority: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_