Patient Information

Please Print
Name_____ **Date**_____/_____/_____

Mailing Address: _____
Street/ PO Box City State Zip
Date Of Birth___/____/_____ **Male/Female (Circle one)** **Social Security #**_____

Email: _____

Telephone: Home_____ **Cell**_____ **Work**_____

Can we text or email you with appointment reminders (Circle one): Yes No

Occupation_____ **Employer**_____

Address/Phone_____

Please Circle One: Single Married Separated Divorced Widowed

Preferred Pharmacy: _____ Initial if we can download your medicines: _____

Name of Primary Care Physician _____

Name of Referring Physician (if applicable) _____

Responsible Party:
❑Self Only → Skip to Insurance Information ❑Other Guarantor → Complete This Section

Guarantor's Full Name_____ Date of Birth: __/___/__ ___

Social Security #_____Patient Relationship to Guarantor: ❑Child❑Spouse❑Other

Address (if different) _____
Insurance Information:
Primary Insurance Company Name_____

Policy #_____ Group #_____

Secondary Insurance Company Name_____

Policy #_____ Group #_____

In case of emergency contact:
Name: _____ Phone: _____
Relationship: _____ Zip Code: _____

Insurance Authorization & Assignment:
The above information is true to the best of my knowledge. I consent to the use and disclosure of my protected health information for treatment, payment and health care operations. I authorize my insurance benefits be paid directly to MS Eye Consultants, LLC as indicated on the claim. I understand that I am financially responsible for all fees and balances, regardless of insurance coverage. Also, I understand that I am responsible for all legal fees, attorney fees, collection fees, and any other charges involved in collection of my account should it be in default.

_____ _____ ____/____/_____
Responsible Party's Signature Patient's Signature Date

Mississippi Eye Consultants

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Mississippi Eye Consultants may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Mississippi Eye Consultants' Notice of Privacy Practices for 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. Mississippi Eye Consultants reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Mississippi Eye Consultants' Privacy Officer at P.O. Box 1520, Oxford, MS 38655.

With my consent, Mississippi Eye Consultants may call my home or other designated 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 call pertaining to my clinical care, including laboratory results among others. With my consent, Mississippi Eye Consultants may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. With my consent, Mississippi Eye Consultants may e-mail to my home or other designated 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 Mississippi Eye Consultants 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.

I understand that I am responsible for the payment of services received. I understand that I am responsible for understanding my insurance and how it relates to the services provided by Mississippi Eye Consultants. I understand that Mississippi Eye Consultants financial policy is to send two statements with no payments received followed by a phone call; if no payment is received, a final statement will be mailed along with a delinquent letter followed by another phone call. If after all of these attempts, no payment is made, I understand that I will be turned over to collections for the remaining balance on my account. If I am on a payment plan, I acknowledge that it is my responsibility to make the payment required of me every month, and if I miss a month, it is at the discretion of Mississippi Eye Consultants to forgo the previously mentioned process and turn me over to collections, immediately. I hereby authorize and consent to the release of all medical and personal information (including but not limited to my home phone, cell phone, work phone, address and email address) by or to Mississippi Eye Consultants and all healthcare professionals involved in my care; interpretation of test results; account billing and collections; payment posting and/or processing; or related healthcare functions. This authorization shall remain in effect until such time as all account balances extending from the encounter have been fully satisfied. I authorize Mississippi Eye Consultants and all clinical providers who have provided care or interpreted my tests, along with any billing service and /or collection agency/attorneys who may work on Mississippi Eye Consultant's behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology or by electronic mail, text messaging or by any other form of electronic communication.

By signing this form, I am consenting to Mississippi Eye Consultants' 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, Mississippi Eye Consultants may decline to provide treatment to me.

_____	_____	____/____/_____
Print Name of Patient or Legal Guardian	Signature of Patient or Legal Guardian	Date

Please list any individuals that we may discuss your health information with:

_____

_____

Patient History

Past Medical History
Please circle all that apply:

Anxiety	Hepatitis	Hearing Loss	COPD
Arthritis	Hypertension	GERD	Depression
Artificial Joints	HIV/AIDS	Valve Replacement	Seizures
Asthma	Hypercholesterolemia	Stroke	Diabetes
Atrial fibrillation	Hyperthyroidism	BPH	Pacemaker
Bone Marrow Transplantation	End Stage Renal Disease	Other:_____	

Cancer
Please circle all that apply:

Breast Cancer	Leukemia	Basal Cell	Squamous Cell
Colon Cancer	Prostate Cancer	Uterine Cancer	Lung Cancer
Ovarian Cancer	Lymphoma	Other: _____	

Past Surgical History
Please circle all that apply:

Appendix Removed	Breast Reduction	Endometriosis
Bladder Removed	Fibroids Hysterectomy	Hysterectomy
Mastectomy (Right, Left, Bilateral)	Colectomy: Colon Cancer Resection	Ovaries Removed
Lumpectomy (Right, Left, Bilateral)	Colectomy: Diverticulitis	Spleen Removed
Breast Biopsy (Right, Left, Bilateral)	Colectomy: IBD	Skin Biopsy
Gallbladder Removed	Coronary Artery Bypass	Heart Transplant
Mechanical Valve Replacement	Biological Valve Replacement	Breast Implants
Knee Replacement (Right, Left, Bilateral)	Hip Replacement (Right, Left, Bilateral)	Kidney Stone Removal
Kidney Biopsy or Transplant	Kidney Removed (Right, Left)	Prostate Removed
Prostate Biopsy TURP	Testicles Removed (Right, Left, Bilateral)	Other: _____

Family History
Please circle all that apply & list relationship to diagnosed:

Blindness	Cancer	Cataracts	CVA	Diabetes
Glaucoma	Heart Disease	Migraine	Strabismus	
Retinal Detachment	Macular Degeneration	None	Other: _____	

Ocular History
Please circle all that apply:

Allergic Conjunctivitis	Diabetic Retinopathy (Right, Left)	Blepharitis
Dry Eyes	Cataract (Right, Left, Both)	Glaucoma (Right, Left)
Corneal Dystrophy (Right, Left, Both)	Macular Degeneration (Right, Left)	Ophthalmic Migraine
Macular ERM (Right, Left)	Narrow Angles (Right, Left)	PVD (Right, Left)
Ocular Hypertension (Right, Left)	Pseudo exfoliation (Right, Left)	Retinal Tear (Right, Left)
Strabismus (Right, Left)	Floaters (Right, Left)	None
Other: _____		

Ocular Surgical History
Please circle all that apply:

Blepharoplasty (Right, Left)	Corneal Transplant (Right, Left)	Laser PI (Right, Left)
Cataract Surgery (Right, Left)	DSAEK (Right, Left)	PRK (Right, Left)
Eye Muscle Surgery	Intravitreal Injections (Right, Left)	Tube Shunt (Right, Left)
Lasik (Right, Left)	SLT/ALT Glaucoma Laser (Right, Left)	Ptosis Repair (Right, Left)
Punctal Plugs (Right, Left)	Retinal Laser (Right, Left)	None
Trabeculectomy (Right, Left)	YAG Capsulotomy (Right, Left)	Other: _____

Social History

Do you smoke? Yes No Have you ever smoke? Yes No When did you quit? _____
Do you use illicit drugs? Yes No Have you ever? Yes No
Do you drink alcohol? Yes No How many do you consume in a day? _____
Primary Care Physician: _____ Pharmacy/Town:_____

Please List All Current Medications or Vitamins including dosage & how often you take them:

_____

_____

_____

Allergies

Please List All Allergies & Reactions:

_____

_____

_____

For patients 65 & older:

Have you had your pneumonia vaccination? _____

Do you have a health care proxy in the event you are unable to make your own medical decisions?
Do you have a living will?
Which statement best reflects your wishes on advanced care recommendations?
__ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
__ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.
__ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Current Eye Condition

Are you having a problem? _____Or need eye exam? _____
Approximately how long have you been having this problem? _____
Did this problem start suddenly or was it gradual in onset? _____
Have you had this problem before? _____
Does this problem seem to be related to any other problem that you are experiencing?
_____
Approximately how long has your vision been as bad as it is now? _____
Which eye seems worse? __Right __Left __About the same
Have you had any recent eye injury or eye surgery? _____
Approximately how long has it been since your last eye exam? _____
Who did that exam? _____ How long have you had present glasses? _____
Do you wear contact lenses? _____ Do you sleep in them? _____

Please check the following vision problems, if any, that you are experiencing with glasses/contacts:

__Difficulty reading
__ Eye pain
__Difficulty sewing/ threading a needle
__Seeing halos or streaks around lights
__Seeing multiple images
__Eye pain in bright lights
__Flashing lights or a curtain over vision
__Difficulty doing jobs or hobbies because of blurred vision
__Difficulty driving at night
__Glare causing blurred vision
__ Difficulty seeing to hunt
__Burning
__Tearing in one or both eyes
__Vision more blurred in sunshine
__Difficulty recognizing people at a distance
__Difficulty seeing at a distance
__Floaters
__Itching
__Matted eyes in mornings
__Difficulty watching tv