EYE&LASER CENTER
OF STARKVILLE

Name:______________________ **Date of Birth**____/____/____ Date______________

MEDICATIONS: List all Prescription and OTC medications you are currently taking.

MEDICATION NAME	REASON TAKEN

Drug Allergies or Reactions:______________________

List all **Major Illnesses** (diabetes, high blood pressure, high cholesterol, heart disease, heart attack, thyroid, stroke, seizure, cancer, etc.) and **Injuries** (concussion, etc.):______________________

List any **Surgeries** you have had (cataract, appendectomy, etc.):______________________

Do you **currently** have any problems in the following areas? If YES, please provide additional information in the space below.

	YES	NO	DETAILS
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL CONSTITUTION (fever, heat stroke, weight loss, weight gain, unusually tired, etc.)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high blood pressure, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, shortness of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES (Are you pregnant? Nursing?)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia, etc.)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY:

Has any member of your family had these diseases?

	YES	NO	UNKNOWN
Blindness	☐	☐	☐
Glaucoma	☐	☐	☐
Diabetes	☐	☐	☐
Hypertension	☐	☐	☐
Heart Disease	☐	☐	☐
Stroke	☐	☐	☐
Cancer	☐	☐	☐
Thyroid	☐	☐	☐
Arthritis	☐	☐	☐

SOCIAL HISTORY:

Do you drink alcohol?	Yes / No	If Yes, how often?________
Do you smoke?	Yes / No	If Yes, how often?________
Do you use illegal drugs?	Yes / No	If Yes, how often?________

What is your occupation?______________________

Physician Signature______________________

ROS Reviewed

STAFF	DATE

PATIENT INFORMATION

NAME ______________________________
FIRST MIDDLE LAST

DATE OF BIRTH ___/___/___ SOCIAL SECURITY # ______________

HOME PHONE # ______________ CELL # ______________ WORK # ______________

STREET ADDRESS ______________ CITY ______________ STATE ______ ZIP CODE ______

EMPLOYER ______________________________
NAME ADDRESS

OCCUPATION ______________

SEX (CIRCLE) MALE FEMALE MARITAL STATUS (CIRCLE) S M W D

EMAIL ADDRESS ______________

RESPONSIBLE PARTY ______________ RELATIONSHIP ______________
(COMPLETE IF PATIENT IS A MINOR) NAME PHONE#

EMERGENCY CONTACT ______________________________
NAME PHONE #

POWER OF ATTORNEY ______________________________
NAME PHONE #

(*MUST HAVE ALL SUPPORTING DOCUMENTATION***)**

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER ______________________________
NAME ADDRESS PHONE#

INSURED NAME ______________ INSURED DATE OF BIRTH ___/___/___

INSURED SOCIAL SECURITY # ______________

POLICY # ______________ GROUP # ______________

SECONDARY INSURANCE CARRIER ______________________________
NAME ADDRESS PHONE #

INSURED NAME ______________ INSURED DATE OF BIRTH ___/___/___

INSURED SOCIAL SECURITY # ______________

POLICY # ______________ GROUP # ______________

IS THIS WORKER'S COMP? (CIRCLE) YES NO IF SO, DATE OF INJURY ___/___/___

ASSIGNMENT OF BENEFITS & FINANCIAL AGREEMENT

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/OTHER INSURANCE COMPANY BENEFITS BE MADE TO JAMES S. BROWN, III, M.D. FOR ANY SERVICES FURNISHED ME BY THE PARTY/PHYSICIAN WHO ACCEPTS ASSIGNMENT. I UNDERSTAND IT IS MANDATORY TO NOTIFY THE HEALTH CARE PROVIDER OF ANY OTHER PARTY WHO MAY BE RESPONSIBLE FOR PAYING FOR MY TREATMENT. (SECTION 1128B OF THE SOCIAL SECURTIY ACT AND 31 U.S.C. 3801-3812 PROVIDES PENALTIES FOR WITHOLDING THIS INFORMATION.) REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIER OR ANY OTHER INSURANCE COMPANY ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE/OTHER INSURANCE COMPANY OR A RELATED MEDIGAP CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I REALIZE THAT THE INSURANCE BENEFITS MAY NOT PAY THE ENTIRE BILL AND I AGREE TO PAY THE DIFFERENCE OF THE ENTIRE BILL, IF NECESSARY. IN THE EVENT OF DEFAULT IN THE PAYMENT OF MY CHARGES, I AGREE TO PAY ALL COSTS OF COLLECTIONS, INCLUDING A REASONABLE ATTORNEY'S FEE, SHOULD THE ACCOUNT BE REFERRED TO AN ATTORNEY FOR COLLECTION.

SIGNATURE ______________________________ DATE ______________

EYE&LASER CENTER
OF STARKVILLE

Patient Name ______________________________ **Chart #** ______________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have received the Notice of Privacy Practices issued by Eye & Laser Center of Starkville.

Patient Signature: ______________________________ **Date:** ______________

Parent/Guardian Signature ______________________________ **Relationship:** ______________

PERSONAL HEALTH INFORMATION PRIVACY

I understand that the physician and staff of Eye & Laser Center of Starkville will not discuss my health information with my family or friends unless I expressly authorize them to do so. I may revoke this authorization at any time in writing. I hereby authorize the physician and staff of Eye & Laser Center of Starkville to convey information about my health to the following people. I understand that by leaving all spaces blank I am indicating my choice to a "No Information" patient, and I do not want my information released to anyone else.

Name ______________________ Phone # ______________ Relationship ______________

Name ______________________ Phone # ______________ Relationship ______________

Name ______________________ Phone # ______________ Relationship ______________

Name ______________________ Phone # ______________ Relationship ______________

I authorize Eye & Laser Center of Starkville to leave scheduling information or other aspects of my care by the following methods: (circle method and write number to the side)

Voice Telephone Message			**Phone Number**
Home	yes	no	______________
Work	yes	no	______________
Cell	yes	no	______________

I assume responsibility to notify Eye & Laser Center of Starkville when this information changes.

FINANCIAL POLICY ACKNOWLEDGMENT

I acknowledge that I have read and understand Eye & Laser Center of Starkville's Financial Policy. I understand that I am ultimately financially responsible for all medical fees relating to my care. Should my insurance deny for any such reason as an authorization, deductible, or non-covered service, I understand that I will be responsible for my bill.

Patient Signature: ______________________________ **Date:** ______________

Parent/Guardian Signature: ______________________________ **Relationship:** ______________