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 _____ RACE _____

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

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 _____

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:** _____

EYE&LASER CENTER
OF STARKVILLE

Name: _____
Date of birth: _____

We are happy to welcome you to our office! Please take a moment to fill out this form as completely as you can. If you have any questions, we'll be glad to help you.

MEDICATIONS (include dose and frequency if possible):

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

ALLERGIES:

_____
_____
_____
_____
_____
_____

SURGICAL HISTORY:

_____
_____
_____
_____
_____
_____

Primary care doctor: _____

Please check any of the following medical conditions that apply:

O Poor vision
O Eye pain
O Watering
O Redness
O Loss of vision
O Chills
O Weight loss
O Stuffy nose
O Cough
O High blood pressure
O Rapid heart beat
O Wheezing
O Shortness of breath
O Upset stomach
O Constipation
O Burning on urination
O Incontenince
O Joint pain
O Stiffness
O Arthritis
O Rash
O Headache
O Seizure
O Stroke
O Paralysis
O Anxiety
O Depression
O Insomnia
O Diabetes
O High cholesterol
O Thyroid abnormalities
O Anemia
O Allergies

Please check any of the following eye conditions that apply:

O Cataracts
O Glaucoma
O Macular degeneration
O Retinal tear/detachment
O Floaters
O Dry eye
O Diabetic retinopathy
O Macular edema

Family History:

O Glaucoma
O Blindness
O Cancer
O Macular degeneration
O Thyroid
O Heart disease
O Hypertension

Smoking status (please circle which applies): Never smoker Current smoker Former smoker

Patient signature: _____