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** _____

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

Please check any of the following eye conditions that apply:

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

Family History:

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

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

Patient signature: _____