20/20 EYE CARE

REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____
City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Birthdate_____ SS#_____

Occupation_____

Spouse's Employer_____

Do you have a scheduled appointment? Yes ☐ No ☐

If Yes, Which Doctor_____

If No, Would you like the first available?_____

2 INSURANCE

Who is responsible for this account?_____

Relationship to Patient _____

Insurance Co. _____

Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name_____

Birthdate_____ SS#_____

Relationship to Patient_____

Insurance Co. _____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

3 PHONE NUMBERS

Home_____ Work_____ Ext._____ Spouse's Work_____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4 EYE HEALTH HISTORY

Date of last Eye exam? _____

Name of Eye doctor _____

Do you wear glasses? ☐ Yes ☐ No

☐ All the time ☐ Occasionally

☐ Reading ☐ Driving ☐ TV

Do you wear contacts? ☐ Yes ☐ No

Type_____ Hours/Day_____

Describe any problems you have with your contacts _____

_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bloodshot Eyes	☐ Yes ☐ No	Floaters or Spots	☐ Yes ☐ No
Blurred Vision - Distance	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Blurred Vision - Near	☐ Yes ☐ No	Headaches	☐ Yes ☐ No
Burning Eyes	☐ Yes ☐ No	Itching Eyes	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Light Sensitive	☐ Yes ☐ No
Color Vision, Poor	☐ Yes ☐ No	Loss of Vision	☐ Yes ☐ No
Crossed Eyes	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No
Discharge from Eyes	☐ Yes ☐ No	Night Vision, Poor	☐ Yes ☐ No
Dizzy Spells	☐ Yes ☐ No	Red Eyes	☐ Yes ☐ No
Double Vision	☐ Yes ☐ No	Seeing Halos	☐ Yes ☐ No
Dry Eyes	☐ Yes ☐ No	Seeing Flashes	☐ Yes ☐ No
Eye Infection	☐ Yes ☐ No	Temporary Loss of Vision	☐ Yes ☐ No
Eye Injury	☐ Yes ☐ No	Twitching Eyelid	☐ Yes ☐ No
Eye Strain	☐ Yes ☐ No	Vision Poor	☐ Yes ☐ No
Fainting Spells, Blackouts	☐ Yes ☐ No	Watering Eyes	☐ Yes ☐ No

- OVER -

5 HEALTH HISTORY

Physician's Name_____ Date of last visit_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also, place a mark to indicate if a blood relative has had any of the following problems.

	Yourself		Family Members			Yourself		Family Members	
AIDS / HIV	☐ Yes	☐ No	☐ Yes	☐ No	Hepatitis (Type_____)	☐ Yes	☐ No	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	☐ Yes	☐ No	Lazy Eye	☐ Yes	☐ No	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	☐ Yes	☐ No	Lupus	☐ Yes	☐ No	☐ Yes	☐ No
Bleeding	☐ Yes	☐ No	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	☐ Yes	☐ No
Blindness	☐ Yes	☐ No	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	☐ Yes	☐ No	Poor Color Vision	☐ Yes	☐ No	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	☐ Yes	☐ No	Retinal Disease	☐ Yes	☐ No	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	☐ Yes	☐ No	Shingles	☐ Yes	☐ No	☐ Yes	☐ No
Drug Sensitivity	☐ Yes	☐ No	☐ Yes	☐ No	Skin Conditions	☐ Yes	☐ No	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	☐ Yes	☐ No	Thyroid Conditions	☐ Yes	☐ No	☐ Yes	☐ No
Eye Surgery	☐ Yes	☐ No	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	☐ Yes	☐ No	Turned Eye	☐ Yes	☐ No	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	☐ Yes	☐ No	Are you pregnant?_____			Number of Children_____	
Heart Condition	☐ Yes	☐ No	☐ Yes	☐ No	Tobacco Use_____			Alcohol Use_____	

MEDICATIONS

List medications you are currently taking, including eye drops:

_____

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

List your allergies to medications or other substances:

_____

_____

_____

_____

_____

_____

6 MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits either be made to me or on my behalf to Dr._____ for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in 9 or the HCFA-1500 form, or elsewhere on the approve claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon charge determination of the Medicare carrier.

_____ _____

Signature of Beneficiary Date

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICE

20/20 EYECARE

DANIEL W. PURVIS, O.D.

2464 WEST MAIN STREET, SUITE 3

DOTHAN, AL 36301

I acknowledge that the above provider has made a good faith effort to obtain my written acknowledgement of receipt of its Notice of Privacy Practices. I understand that this notice provides a description of Protected Health Information **(PHI)** uses and/or disclosures. I understand that I have the right to request restrictions as to how my **PHI** may be used, and/or disclosed. I understand that the provider is not required to agree to the restriction I request. I understand that my refusal does not prohibit the provider from providing services, or from using or disclosing **PHI** as permitted by law.

MY SIGNATURE ATTESTS THAT I HAVE ACCEPTED or REFUSED THE ABOVE NAMED PROVIDER'S NOTICE OR PRIVACY PRACTICES AS INDICATED.

[ ] ACCEPTED

[ ] REFUSED- REFUSAL DOES NOT PROHIBIT THE PROVIDER FROM RENDERING SERVICE OR FROM USING OR DISCLOSING PROTECTED HEALTH INFORMATION AS PERMITTED BY LAW.

PLEASE LIST THE REASONS FOR THE REFUSAL ON THE LINE BELOW

_____

PATIENT SIGNATURE _____

DATE_____

AUTHORIZED REPRESENTATIVE AND RELATIONSHIP _____

(Complete if signing for patient)

Patient Name: _____**Telephone:**_____

[ ]Noted in Computer [ ]Return Mail Requested Date:_____ **Emp:**_____

[ ]Reviewed [ ]Telephoned

Action Taken:_____

_____

20/20 EYE CARE

Dr. Daniel W. Purvis, Optometrist

2464 W. Main St., Suite 3 Dothan, AL 36301 (334) 792-2020

INFORMATION ON DILATION OF PUPILS

In order for our office to adequately perform the assessment and evaluation of your eyes, we will instill drops that will dilate the pupil. The effect of these drops is to temporarily blur the vision and make your eyes sensitive to lights. Please be extra careful in your activities until the effects of the drops wear off.

Consent to Dilate _____ Date _____

Side Effects:

RARELY, In a susceptible patient the drops can cause a rise of pressure inside the eye. It is impossible to tell ahead of time with 100% certainty, which patients are going to have this. The increase in pressure in your eye may show itself by causing your vision to have halos or rings around lights, objects may become smokey, steamy or foggy and there may be discomfort or pain in the eye or the area around the eye. The pain is usually quite severe and new and when combined with the blurred vision and halos around lights, may be a sign that the pressure built up and may require treatment. If this does occur to you, please call the office and arrange to be seen as soon as possible so that we may check this for you and treat if necessary.

As mentioned earlier, this condition occurs VERY RARELY and only in susceptible individuals and, fortunately, can almost always be treated successfully. Again, remember the reason we dilate pupils is to do a better, more thorough eye examination. There is always a slight chance that this dilation can cause pressure rise that may need to be treated. If you feel you are having this problem, please call the office.

If we can be of any other assistance of service to you at any time, please let us know.