Patient Name:____ **Date:**__________________

Last First Middle Initial

Address:____ **City:**____________________

State:_________ **Zip:**_________________ **DOB:**____________________ **SS#**____________________

Preferred Phone #: (______)________-__________
Circle: Cell / Home / Work

Secondary Phone #: (______)________-__________
Circle: Cell / Home / Work

Email:______________________________________ *Practices are required to obtain this to offer patients a web portal.

Emergency Contact:____________________________ **Relationship:**______________ **Phone#:**______________

DEMOGRAPHICS

(The American Recovery and Reinvestment Act of 2009 requires practices to use Electronic Health Records and collect this data for statistical purposes only.)

Gender: ☐ Male ☐ Female	**Race:** ☐ American Indian or Alaska Native ☐ Black ☐ White ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ Other
Preferred Language: ☐ English ☐ Other	**Ethnicity:** ☐ Hispanic or Latino ☐ Non-Hispanic or Latino
Occupation:	☐ Retired ☐ Student ☐ Disabled ☐ Homemaker ☐ Unemployed

SOCIAL HISTORY

Tobacco use: ☐ Never smoked ☐ Former smoker ☐ Current some day smoker ☐ Current every day smoker		
Alcohol use: ☐ None ☐ Socially ☐ Moderate ☐ Heavy ☐ Alcoholic ☐ Recovering Alcoholic		
Street Drug use: If yes, please list. ☐ None	**Are you pregnant?** ☐ Yes ☐ No ☐ N/A (Male)	
Have you ever received a pneumonia vaccine? ☐ Yes ☐ No	**Primary Care Physician:**	**Eye Care Physician:**
Who referred you:		
Pharmacy name/address:	**Date of last eye exam:**	

INSURANCE

Primary Insurance:	**ID#:**	**Subscriber Name:**	**Relationship to Patient:** ☐ Self ☐ Spouse ☐ Parent
(If other than patient, please fill in the following)	**Subscriber DOB:**		**SS#:**
Secondary Insurance:	**ID#:**	**Subscriber Name:**	**Relationship to Patient:** ☐ Self ☐ Spouse ☐ Parent
(If other than patient, please fill in the following)	**Subscriber DOB:**		**SS#:**

I, the undersigned patient or guarantor, certify that I have active coverage with the above insurance companies and assign directly to Dr. Jay Thompson 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 understand it is my responsibility to ensure network participation and obtain any authorizations that may be required by my insurance in order to receive maximum benefits. I understand that all **COPAYS** are due and payable at the time of service, and agree to pay any applicable **CO-INSURANCE** and **DEDUCTIBLE** amounts not collected at the time of service, within 30 days, unless I have made prior arrangements for a payment plan with Dr Thompson's office staff. Please contact your insurance company to fully understand your benefits and your financial responsibilities for the services you may require. Our office staff is ready to assist you in any way we can.

I have received a copy of Lowcountry Eye Specialists Notice of Privacy Practices. Please initial (____)

Patient or Guarantors Signature:____ **Date:**__________________

Print name of above if other than patient:__________________________________ **Relationship:**____________

(Form updated 09/06/2018)

Lowcountry Eye Specialists
Communication Authorization

Patient Name:____DOB:_________________

- Initial here______if you do not want your healthcare information discussed with anyone other than yourself.
- If you would like us to discuss your healthcare information (e.g. test results, prescription information etc.) with anyone other than yourself (spouse, family members), please list below any individuals whom you authorize.

Purpose of request- I authorize **LOWCOUNTRY EYE SPECIALISTS** to disclose or provide protected health information, about me to the individual(s) listed below.

Who will be authorized to receive information? (list the individual/entity who is to receive your information)

Name_______________________________________ Relationship to patient_________________

Name_______________________________________ Relationship to patient_________________

Name_______________________________________ Relationship to patient_________________

Name_______________________________________ Relationship to patient_________________

Description of information to be disclosed- I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

All of my past, present and future health information

OR

All of my past, present, and future health information with the exception of the following information:

Mental health records | Alcohol/drug abuse treatment

Communicable diseases (including HIV and AIDS) | Other (please specify):________________________

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

Patient Request | Other (please specify)____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year:_______________________
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person (s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

Please sign the next available signature line below

Patient Signature____ Date_______________________________

(Form created May 2015 / updated 04-17-18)

You have the right to receive a copy of signed authorizations upon request

Lowcountry Eye Specialists

DATE: ________/________/________

PATIENTS NAME: ____ DOB: ________/________/________

PLEASE DESCRIBE THE REASON FOR YOUR VISIT: ____

____

EYE HISTORY: Have you experienced or been diagnosed with any of the following:

☐ Cataracts ☐ Dry Eyes ☐ Diabetic Retinopathy ☐ Glaucoma ☐ Macular Degeneration

☐ Retinal Detachment ☐ Eye Injury or trauma (If yes, please explain) ______________________________

Have you had previous eye surgery? ☐ Yes ☐ No (If yes, please fill in the details below)

Eye: ☐ Right ☐ Left Procedure: ______________________________ Surgeon: ________________ Date: ____________

Eye: ☐ Right ☐ Left Procedure: ______________________________ Surgeon: ________________ Date: ____________

Have you ever, or do you currently wear contacts? ☐ Yes ☐ No (If yes, please fill in the details below)

Date last worn: _________________ Brand: ______________________ Power: Right Eye __________ Left eye _________

Do you currently use eye drops? ☐ Yes ☐ No (If yes, please fill in the details below)

Name of drop: ________________________________ Frequency Used:_______________ Eye(s): ☐ Right ☐ Left ☐ Both

Name of drop: ________________________________ Frequency Used:_______________ Eye(s): ☐ Right ☐ Left ☐ Both

DRUG ALLERGIES:

☐ None ☐ Aspirin ☐ Codeine ☐ Sulfa ☐ Penicillin ☐ Other ______________________________________

MEDICAL HISTORY:

☐ Aids / HIV+
☐ Acid Reflux
☐ Allergies (seasonal)
☐ Alzheimer's
☐ Anxiety
☐ Arthritis
☐ Artificial Heart Valve
☐ Artificial Joints
☐ Asthma
☐ Bleeding Disorder
☐ Cancer (Type: _________________)
☐ Chemical Dependency
☐ Other ___________________________

☐ COPD
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ Dementia
☐ Depression
☐ Diabetes (☐ Type 1 ☐ Type 2 Insulin: ☐ Yes ☐ No)
☐ Drug Sensitivity
☐ Emphysema
☐ Epilepsy
☐ Heart Condition (Type: _________________)
☐ High Blood Pressure
☐ High Cholesterol
____

☐ Hepatitis (Type: _______)
☐ Kidney Disease
☐ Lupus
☐ Migraines
☐ Pacemaker
☐ Rheumatoid Arthritis
☐ Rheumatic Fever
☐ Shingles
☐ Skin Condition (Type:_____)
☐ Stroke (Date:____________)
☐ Thyroid Condition
☐ Tuberculosis
____

CURRENT MEDICATIONS: (Please include the name, dosage, & frequency)

☐ None_________________ ___________________ ___________________ ___________________

___________________ ___________________ ___________________ ___________________

___________________ ___________________ ___________________ ___________________

PREVIOUS SURGERIES:

☐ None _________________ ___________________ ___________________ ___________________

FAMILY HISTORY: Have any of your immediate family (Father, Mother, Grandparent, Sibling) been diagnosed with the following?

☐ Cataract (Relation to you: _______________) ☐ Diabetes (Relation to you: _______________)

☐ Glaucoma (Relation to you: _______________) ☐ Macular Degeneration (Relation to you: _______________)

☐ Other (Relation to you: _______________) **☐ Unknown** **☐ Adopted**

DILATION

Dilating drops are used to dilate or enlarge the pupil of the eye. This is necessary for the doctor to perform a complete examination of the retina and the back of the eye. Dilation frequently changes vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for us to predict to what degree your vision will be affected. Driving may be difficult immediately after your examination. If you feel that you cannot safely drive after being dilated, we recommend that you make alternative transportation arrangements. However, a large number of patients do drive after dilation with the assistance of temporary sunglasses, which we can provide for you after your dilation. Please be cautious and determine what is best for you.

REFRACTION

A refraction is a diagnostic test used to determine the best possible visual acuity and function of your eye. It is a critical part of any complete eye exam and MUST be done if you are here for a cataract evaluation, have any vision complaints, experience a change in your vision, and/or you would like a prescription for glasses.

As indicated by the federal government, a refraction is a non-covered service by most medical insurance plans including Medicare and Medicaid as they consider this a “vision” service, not a “medical” service. The fee for a refraction is **$40.00** and is collected at the time of service in addition to any co-pays or deductibles your insurance plan may require. If you do not want this test done, please notify the technician during your exam.

*If you are here for a cataract evaluation and have had a refraction within 90 days, we will attempt to get a copy of it from your Optometrist, so you don’t have to have it repeated.

MEDICATION HISTORY

Our office uses an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your medication history. A medication history is a list of prescription medicines that have recently been prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer. An accurate medication history is very important in helping us treat you properly and in avoiding potentially dangerous drug interactions. Please check one of the boxes below indicating if you give us permission to obtain your medication history.

I give permission for you to obtain my medication history

I do **not** give permission for you to obtain my medication history

PRACTICE POLICIES

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Our doctor(s) will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

We value our patients and make every effort to have your visit be a pleasant experience with minimum waiting times. Please be aware you may be asked to reschedule your visit for any of the following:

- Arriving more than 15 minutes late for your appointment
- Taking more than 15 minutes to fill out paperwork
- Disturbing other patients with loud cell phone calls, un-attended children etc…
- Unwilling to complete and sign paperwork, produce verifiable insurance or photo ID
- Unable to pay past due balances, co-pays, deductibles, co-insurance or self-pay amounts due at time of service.

Your health is our number one concern, however we require you to be active participants in your care. Please be aware you may be discharged from the practice, for any of the following:

- Verbally abusive, threatening or violent behavior
- Frequently failing to show up for appointments or rescheduling at the last moment
- Non-compliance to a prescribed treatment plan
- Changing to an insurance plan that we do not participate with
- Unresolved past due balances, or failure to meet payment schedules

Acknowledgment: By signing below I acknowledge that I have read and understand the above information.

Patient Signature:______________________________ **Date:**____________________

(updated 08/08/19)