601 Providence Park Drive
Mobile, AL 36695
Tel 251-650-2020
Fax 251-650-1010

Please make any necessary changes (and complete) to these pages and sign where indicated

Patient First Name		M.I.		Last Name		Today's date	05/05/2014
Date of Birth	\ \			Height		Weight	

Whom may we thank for referring you?

MD First Name		M.I.		Last Name			
Street Address		City		State		Zip	
Phone Number							

In addition, to the referring doctor listed above, please list any other doctors that you have seen for this condition, as well as your **internist** or **general physician** so that we may keep them informed our findings.

MD First Name		M.I.		Last Name			
Specialty							
Street Address		City		State		Zip	
Phone Number							

MD First Name		M.I.		Last Name			
Specialty							
Street Address		City		State		Zip	
Phone Number							

Please answer the following questions about your medical history:

Have you ever had any eye disease?

☐ Cataract ☐ Glaucoma ☐ Macular degeneration ☐ Dry eye ☐ Blepharitis ☐ Strabismus ☐ other _____

Have you had any eye surgery?

☐ Cataract ☐ Glaucoma ☐ Laser ☐ Cosmetic ☐ Retina ☐ Eye Muscle ☐ Refractive ☐ other _____

Do any medical or eye diseases run in your family?

☐ Diabetes ☐ Hypertension ☐ Heart disease ☐ Heart attack ☐ Glaucoma ☐ other _____

Have you ever been treated for any medical conditions?

☐ Diabetes ☐ Hypertension ☐ Heart disease ☐ Heart attack ☐ Lung disease ☐ Thyroid ☐ Arthritis ☐ other _____

Have you ever had any surgery not listed above? ☐ no; ☐ yes Please explain _____ _____

Have you ever been hospitalized ☐ no; ☐ yes Please explain and provide date and reason? _____

Have you ever been treated for ☐ fibromyalgia syndrome (FMS) ☐ chronic fatigue syndrome (CFS).

Smoking Status: ☐ Current Every day Smoker ☐ Current Some day Smoker ☐ Former Smoker ☐ Never Smoker
☐ Unknown if ever smoked ☐ Heavy Tobacco Smoker ☐ Light Tobacco Smoker ☐ Smoker, current status unknown

How much alcohol do you drink per week? _____

How many hours/week do you work? _____

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Review of Systems (check box if *you* have any of the following and please explain:

Skin: ☐ rashes ☐ excessive dryness ☐ other _____ ☐ none

Ear/nose/throat problems ☐ hearing loss, ☐ sinus problems ☐ sore throat ☐ other _____ ☐ none

Heart ☐ chest pain ☐ irregular heart beat ☐ other _____ ☐ none

Endocrine ☐ Diabetes ☐ Thyroid ☐ other _____ ☐ none

Respiratory problems ☐ shortness of breath ☐ wheezing, ☐ coughing ☐ other _____ ☐ none

Chronic fever ☐ unexpected weight loss/gain, ☐ fatigue ☐ other _____ ☐ none

Gastrointestinal problems ☐ heartburn ☐ abdominal pain ☐ diarrhea ☐ vomiting ☐ other _____ ☐ none

Urinary problems ☐ pain or discomfort ☐ blood in urine ☐ none ☐ other _____ ☐ none

Musculoskeletal problems ☐ muscle aches ☐ joint pain ☐ and swollen joints ☐ other _____ ☐ none

Neurologic problems ☐ numbness ☐ weakness, ☐ headaches ☐ paralysis ☐ other _____ ☐ none

Psychiatric problems ☐ depression ☐ anxiety ☐ other _____ ☐ none

Cancer ☐ benign ☐ malignant ☐ other _____ ☐ none

Do you take any *pills*?

Name of Medicine	*Dose*	*For what condition*	How often

Do you take any eye *drops or ointments*?

Name of Medicine	*Dose*	*For what condition*	How often

Do you have *ALLERGIES* to any medicines?

Name of Medicine	Describe reaction	Name of Medicine	Describe reaction
1.		4.	
2.		5.	
3.		6.	

Do you have an allergy/sensitivity to LATEX? _____ **What reaction do you have?** _____

I authorize the release of medical records, X-rays, pathology reports or pathology slides to Vision Partners, LLC, Mobile Alabama. (Please fax to 251-650-1010). I further authorize the use of my photograph(s) for teaching and/or educational purposes.

05/05/2014

Patient Signature Doctor Signature

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DATE: 05/05/2014

☐ **New Patient** ☐ **Existing Patient**

Patient's First Name		**M.I.**		**Last Name**	
Address Line 1					
Apt #					
City		**State**		**Zip Code**	
Date of Birth	\ \	**Sex**	☐ Male ☐ Female		
Social Security Number					
Home Phone					
Cell Phone					
Email					
Marital Status	☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed**				
Race	☐ **Hispanic Origin** ☐ **Non-Hispanic Origin** ☐ **American Indian** ☐ **Asian** ☐ **Black** ☐ **Native Hawaiian** ☐ **White**				

Your *Primary Medical* Doctor: _____

Referring Doctor: First Name _____ Last Name _____

Responsible Party (Name: Self, Spouse or Parent/Guardian)

Name: _____ SS# _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Place of Employment (Self or Parent) _____ Phone # _____

Occupation (Patient): _____

Place of Employment (Spouse) _____ Phone # _____

In case of emergency:

Relative's Name _____

Relationship: ☐ Parent/Legal Guardian ☐ Sibling ☐ Spouse ☐ Child ☐ Friend

Phone # _____ Friend's Name _____ Phone # _____

Insurance Information:

Primary Insur. Company: _____ **Policy #** _____

Group # _____

Insured Name on Card		Insured SSN:	
Insured Date of Birth			

Relationship to Patient: ☐ Parent/Legal Guardian ☐ Sibling ☐ Spouse ☐ Child ☐ Friend

Secondary Insurance Company: _____ Policy # _____

Group # _____ Insured Name on Card: _____ Insured Date of Birth: _____

Relationship to Patient: ☐ Parent/Legal Guardian ☐ Sibling ☐ Spouse ☐ Child ☐ Friend

:

If Accident Related give **DATE OF ACCIDENT** _____

Was it a work related accident? Yes ☐ No ☐

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FINANCIAL RESPONSIBILITIES: The undersigned, in consideration of medical services to be rendered Vision Partners, LLC to the above named patient, does hereby agree to pay Vision Partners, LLC on demand of said services and incidentals incurred on behalf of such patient. Accounts not paid in full are subject to an interest charge, penalties and/or claims in court.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: The hospital and attending physician are authorized to release any medical information required in the processing of application for financial coverage for all services rendered to the patient.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize direct payment of medical benefits to the attending physicians or to whomever he designates. I understand that I am personally responsible to the physician for all charges for services.

ACKNOWLEDGEMENT OF REMINDER/RECALLS/CELL PHONES: I understand that Vision Partners utilizes automated phone calls, pre-recorded/artificial voice messages and/or use of automatic dialing device post cards, e-mail and/or text messages to remind patients regarding their appointments, eyeglass order and account balance due. You agree, in order for us to service your account or to collect monies you may owe, VISION PARTNERS, LLC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. I have read this disclosure and agree that VISION PARNTERS, LLC, its employees and/or agents may contact me as described above.

PATIENT PORTAL CONSENT: I authorize VISION PARTNERS, LLC to utilize my email address for setup and access to the office Patient Portal, which I can use for viewing, downloading and transmitting health information for myself (and/or child).

_____
Responsible Party Signature

I acknowledge that I received a copy of Vision Partners Notice of Privacy Practices

PATIENT SIGNATURE: _____
RELATIONSHIP TO PATIENT _____
DATE: 05/05/2014

I have read the informational sheet about dilation (available at the front desk) and hereby authorize the doctor and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition

PATIENT SIGNATURE: _____
RELATIONSHIP TO PATIENT _____
DATE: 05/05/2014

MEDICARE & MEDICARE COMPLETE PATIENTS

Statement to Permit Payment of Medicare Benefits to Provider, Physicians and Patient
Payment for services rendered is to be made as follows: "I request that payment of authorized Medicare benefits be made either to me or on my behalf to Vision Partners, LLC for any services or items furnished me by that physician or supplier. 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.

PATIENT SIGNATURE: _____ **DATE**: 05/05/2014

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