Vestavia Eye Care, P.C.

John A. Essinger, II, O.D., M.S James D. Fisk, O.D., Ph.D. Calah O. Ray, O.D.

PATIENT INFORMATION

PATIENT NAME_____GOES BY_____

DR.____REV.____MR.____MASTER____MRS.____MS.____MISS____

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE: HOME _____WORK _____CELL _____ ☐ texting ok

E-MAIL ADDRESS_____

MAY WE THANK SOMEONE FOR REFERRING YOU ?_____

MALE/FEMALE DATE OF BIRTH_____/_____/_____ SOCIAL SECURITY #_____-_____-_____

MARITAL STATUS _____EMPLOYER/SCHOOL_____OCCUPATION_____

PREFERRED LANGUAGE: ENGLISH/SPANISH RACE/ETHNICITY _____

PREFERRED COMMUNICATION METHOD(S): ☐ EMAIL ☐ POSTAL ☐ TELEPHONE ☐ TEXT

SPOUSE OR RESPONSIBLE PARTY INFORMATION

NAME_____☐ PATIENT IS RESONSIBLE PARTY

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE _____WORK PHONE _____ EMPLOYER_____

SOCIAL SECURITY #_____-_____-_____ MALE/FEMALE DATE OF BIRTH_____/_____/_____

INSURANCE INFORMATION

INSURED'S NAME_____☐ PATIENT ☐ SPOUSE/RES PARTY

INSURED'S ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE _____ EMPLOYER_____ MALE/FEMALE DOB ___/___/_____

MEDICAL INSURANCE:_____ID#_____GROUP#_____

VISION INSURANCE:_____ID#_____GROUP#_____

OTHER INSURANCE:_____ID#_____GROUP#_____

I authorize the release of any medical information necessary to my family or caregivers, referring or family physicians , or to process a claim on any insurance company. I hereby assign to and authorize directly to Vestavia Eye Care, P.C. all benefits payable under such an insurance policy. I realize that the insurance benefits may not pay my entire bill and I agree to pay the difference or the entire bill if necessary. In the event of default in the payment of my charges I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court cost, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.

I agree that Vestavia Eye Care, P.C. and/or its agents, in order to service my account or collect monies I may owe, may contact me by telephone at any number associated with my account, including wireless telephone numbers which could incur usage charges. I also agree that I may be contacted through text messages or emails, using any email address I provide. Contact methods may include pre-recorded or artificial voice messages and/or use of automatic dialing devices.

I/we have read this disclosure and agree that Vestavia Eye Care, P.C., its employees and/or agents may contact me/us as described above.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE

Medical and Ocular History Questionnaire

Name: _____ Date: _____

Chief Complaint/Reason for appointment today:_____
Last Eye Exam: ___/___/____ Primary Care Physician:_____ Location:_____

Medical and Ocular History: Are you pregnant and/or nursing? □ no □ yes
List any medical problems you have (i.e. diabetes, high blood pressure, etc.): _____
_____
_____
Are you allergic to any medications? □ no □ yes List: _____
_____
Do you take any medications? □ no □ yes List: _____
_____
List all ocular conditions you have been diagnosed with: _____
_____
List all major injuries, surgeries, and/or hospitalizations you have had: _____
_____
_____
List all ocular surgeries you have had: _____
_____

Social History: Do you use tobacco products? □ no □ yes
Do you drink alcohol? □ no □ yes
Do you use any other drugs? □ no □ yes

Check if you have been exposed to or infected with:
□ Gonorrhea □ HIV
□ Syphilis □ Hepatitis

Family History: Please note any family history (parents, maternal/ paternal grandparents, siblings and/or children) for the following conditions:

	DISEASE/CONDITION	NO	YES	RELATIONSHIP TO YOU
OCULAR:	Macular Degeneration	□	□	_____
	Cataract	□	□	_____
	Crossed Eyes	□	□	_____
	Glaucoma	□	□	_____
MEDICAL:	High Blood Pressure	□	□	_____
	Diabetes	□	□	_____
	Other	□	□	_____

Eyewear: Do you wear glasses? □ no □ yes
Do you wear contact lenses? □ no □ yes Age of current lenses: _____ Type: □ rigid □ soft

Review of Systems: Please note if you have you ever had any problems in the following areas. : (use back if needed)

ALLERGY (food, etc.) □ _____
CARDIOVASCULAR (heart) □ _____
GENERAL (fever, weight loss) □ _____
EARS, NOSE, MOUTH, THROAT □ _____
ENDOCRINE (thyroid, diabetes) □ _____
GASTROINTESTINAL (ulcer, etc) □ _____
GENITOURINARY (kidney, etc) □ _____
HEMATOLOGIC (anemia, etc) □ _____
IMMUNOLOGIC (allergy, lupus) □ _____
INTEGUMENTARY (skin, acne) □ _____
MUSCULOSKELETAL (arthritis) □ _____
NEUROLOGIC (migraine, seizure) □ _____
PSYCHIATRIC □ _____
RESPIRATORY (asthma, etc) □ _____

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Vision and Medical Eye Care Services

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CONSENT FOR TREATMENT & FINANCIAL AGREEMENT

PATIENT'S NAME_____DATE_____

I consent to treatment necessary or desirable to the care of the patient mentioned above, including but not restricted to, dilation drops, pharmaceutical agents, and/or surgical procedures that may be used by the attending doctor of optometry, his technician, or qualified designee.

Dilation of your eyes is necessary to obtain the best view of your retina, but can cause blurred vision and/or glare for several hours. We recommend that you do not drive for the first few hours following dilation. You may return for this dilation on another date or use our phone to call someone to pick you up. I have read this information about dilation and fully understand that driving may not be safe for me or for others. If I choose to drive after dilation, I do so at my own risk and Vestavia Eye Care, P.C. will in no way be held responsible.

I understand that the patient or responsible party is **solely responsible** for payment of all services, although the insurance carrier may be billed for said services. If this account becomes overdue, I agree to pay all reasonable costs of collection including any legal fees.

I understand that some services are not always covered by my insurance company based on the medical necessity. I understand that if any treatment is rejected by my insurance plan as a non-covered procedure, **I will be billed for those services.** I acknowledge as a member of these plans that this office will submit my insurance claim and **I will be responsible for paying all co-pays and/or deductibles at the time of the visit.**

I authorize my insurance company to remit payment of medical benefits directly to this office for services provided.

I hereby authorize the release of all medical records of the patient listed above to the referring and family physicians, as well as all necessary records for the processing of insurance claims.

Signature of Responsible Party:_____Date:_____

Witness Signature:_____Date:_____

Vestavia Eye Care, P.C.

Vision and Medical Eye Care Services
2531 Rocky Ridge Road Ste. 116
Vestavia Hills, AL 35243

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY STATEMENT

_____
NAME OF PATIENT

_____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

_____
RELATIONSHIP TO PATIENT

_____
DATE