COOSA EYE
associates, pc
A Family Eye Care
& Optical Center

PATIENT HISTORY FORM

Welcome to our office. Please be advised that all information in your eye health record is confidential and necessary for comprehensive and quality eye care. Please complete the information requested and read all front sections carefully.

Social Security No. _____ Ethnicity/Race _____

Patient Name_____Birthdate_____Age_____ Date_____

Address_____City_____ St____ Zip_____

Home Phone (____)_____ Work Phone (____)_____ Daytime Phone (____)_____

Cell Phone (____) _____ Email _____

Patient Occupation_____ Spouse (both parents, if child)_____

If Student: Grade_____School_____ Teacher _____

Responsible Party_____Relation to Patient_____

Employer of Responsible Party_____Work Phone (____)_____

Insurance Subscriber Name_____ Social Security No. _____ Date of Birth_____

ALL FEES FOR EXAMINATIONS AND OFFICE VISITS ARE DUE ON THE SAME DAY THE SERVICES ARE RENDERED. Credit is through Visa, MasterCard, or Discover Card only. When glasses, contact lenses or other materials are needed, a 50% deposit must be made before these materials can be ordered. The balance is due upon delivery. **THERE ARE NO EXCEPTIONS TO THIS POLICY.**

To prevent any misunderstanding, please be advised that the patient/guardian or responsible party (not the insurance company) is responsible for the fees of all professional services and materials.

If parents are separated or divorced, the parent or adult bringing the child to the office will be responsible for payment at the time of service.

We accept payment on the following insurance plans for the benefits covered under these plans (the patient must pay any non-covered services and materials as well as any deductible or co-payment.) **Refraction lense prescription determination is a non-covered service by Medicare and other major medical insurance.**

MEDICARE	**PMD (BLUE CROSS/BLUE SHIELD) (Medical only)**	**SOUTHLAND**
MEDICAID	**VISION CARE PLAN (VCP)**	**UNITED HEALTHCARE (Medical only)**

Today's method of payment: **[ ] Cash/Check** **[ ] Charge Card** **[ ]** _____

I have read and agree to the above terms regarding payment of services and materials. Should my account become delinquent and require collection services, I agree to pay all reasonable collection fees. Further, I agree that I have had made available to me the Government's required HIPAA Notice of Privacy statement as understood by this office effective April 14, 2003.

Patient or Responsible Party Signature_____ Date_____

EYEWARE GUARANTEE: "If you find the EXACT same eyewear or contact lenses advertised for less at any retail dispensary anywhere in Alabama within 30 days of purchase from our dispensary, we will refund the difference."

ONE YEAR WARRANTY – on your frames and eyeglass lenses against defects in workmanship and materials.

Name_____ Date_____

Please circle (YES) or (NO) to the following questions: **Medications**

Are you in good health?	YES	NO
Do you have a physician that you see regularly?	YES	NO
Are you taking any prescription drugs?	YES	NO
Are you taking any non-prescription (over the counter) drugs?	YES	NO
Are you taking any street drugs?	YES	NO
Do you smoke?	YES	NO
Do you drink alcohol?	YES	NO
Do you drive?	YES	NO
Do you have difficulty driving?	YES	NO
Do you have problems with your night vision?	YES	NO
Do you wear contact lenses?	YES	NO
If NO, then are you interested in wearing contact lenses?	YES	NO
Is there any blindness in your family?	YES	NO
Have you suffered an eye injury before today's visit?	YES	NO
Have you ever suffered a serious head injury?	YES	NO
Have you ever suffered a high fever?	YES	NO
Have you ever suffered from epilepsy (seizures, convulsions)?	YES	NO

FAMILY HISTORY: Please circle any of the following problems that apply to you as the patient and/or the parents, brothers/sisters or children of patient:

Blindness	Glaucoma	Cataracts	Diabetes	Macular Degeneration
Cancer	Arthritis	Gout	Lupus	Retinal Detachment
Heart Attack	Stroke	Thyroid Disease	TB	High Blood Pressure
Sjogrens Syndrome	Kidney Disease	Liver Disease		

PLEASE DO NOT WRITE BELOW THIS LINE

REVIEW OF BODY SYSTEMS:
Please check ALL categories below that patient CURRENTLY has any problems in:

- ❑ Constitutional (fever, chills, weight loss, headaches)
- ❑ Cardiovascular (heart)
- ❑ Hematopopoietic (blood disorders)
- ❑ Ears, Nose, Mouth, and/or Throat
- ❑ Gastrointestinal; (vomiting, nausea)
- ❑ Genitourinary (kidney stones, frequent urination)
- ❑ Respiratory (lungs/breathing, wheezing, disorders)
- ❑ Neck (aches-discomfort while working at computer)
- ❑ Skin (rashes, etc.)
- ❑ Bones, Joints, and/or Muscles
- ❑ Neurologic (seizures, loss of strength in a limb, numbness/tingling sensations)
- ❑ Endocrine (intolerance of cold or hot weather, drinking a lot of liquids, passing a lot of urine)
- ❑ Allergic/Immunologic

This history has been reviewed. _____ _____
Doctor's Signature Date

Who may we thank for referring you to our office? _____