M. Lloyd Mason, O.D.

The information requested is needed to complete your optometric record. Please answer the questions and fill in the blanks for yourself or your child as completely as possible.

Name _____ Date _____
(Last) (First) (Middle)

Address _____ City _____ Zip _____

Date of Birth _____ Age _____ Sex _____ Social Security # _____

Home Phone # _____ Work Phone _____

Cell Phone # _____ Email: _____

Name of Employer _____

Name of last eye doctor _____ Date of last eye exam _____

What is the reason for your visit today? _____

List any medications you currently take (prescription and over the counter) _____

_____

_____

List any allergies you have _____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (head trauma, etc.) _____

_____

Do you currently have any problems in the following areas? (please circle)

Eyes

Glaucoma	☐ Yes	☐ No	Mucous discharge	☐ Yes ☐ No
Cataracts	☐ Yes	☐ No	Redness	☐ Yes ☐ No
Retinal disease	☐ Yes	☐ No	Sandy or gritty feeling	☐ Yes ☐ No
Itching	☐ Yes	☐ No	Burning	☐ Yes ☐ No
Loss of vision	☐ Yes	☐ No	Excess tearing/watering	☐ Yes ☐ No
Blurred vision	☐ Yes	☐ No	Light sensitivity/Glare	☐ Yes ☐ No
Fluctuating vision	☐ Yes	☐ No	Double vision	☐ Yes ☐ No
Dry Eyes	☐ Yes	☐ No	Eye pain or soreness	☐ Yes ☐ No
Crossed eye/lazy ey	☐ Yes	☐ No	Other _____	

General/Constitutional

Fever ☐ Yes ☐ No

Weight Loss ☐ Yes ☐ NO

Other _____

Do you currently have any problems in the following areas? If "Yes", please explain.

	YES	NO	Explanation of Problem
Ears, Nose, Throat (Sinus or ear infection, chronic cough, etc.)	☐	☐	
Cardiovascular (heart, vessels, etc.)	☐	☐	
Respiratory (Asthma, emphysema, etc.)	☐	☐	

	YES	NO	Explanation of Problem
Gastrointestinal (stomach ulcers, intestinal disease)	☐	☐	
Genital, Kidney, Bladder	☐	☐	
Muscles, Bones, Joints (Arthritis, etc.)	☐	☐	
Skin (Acne, skin cancer, etc.)	☐	☐	
Neurological (Multiple sclerosis, etc.)	☐	☐	
Psychiatric (Anxiety, depression, insomnia)	☐	☐	
Endocrine (Diabetes, Hyperthyroid, etc.)	☐	☐	
Blood/Lymph (high cholesterol, anemia, etc.)	☐	☐	
Allergic/Immunologic (Hay fever, Lupus, Sjogren's, etc.)	☐	☐	

Family History

Has anyone in your family ever had any of the following conditions? If yes, who?

Disease	YES	NO	Relationship to Patient
Blindness	☐	☐	
Glaucoma	☐	☐	
Macular Degeneration	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Thyroid Disease	☐	☐	
Other	☐	☐	

Social History

Current Occupation _____

Marital Status (please circle): married ☐ divorced ☐ single ☐ widowed ☐

Do you drive? ☐YES ☐NO

Do you have visual difficulty when driving? ☐YES ☐NO

Do you problems with night driving? ☐YES ☐NO

Have you ever tried to wear contact lenses? ☐YES ☐NO

Do you currently wear contact lenses? ☐YES ☐NO

Do you currently wear glasses? ☐YES ☐NO

Do you drink alcohol? ☐YES ☐NO

If YES: ☐occasional ☐1/day ☐2-3/day ☐4+/day

Do you smoke? ☐YES ☐NO

If YES: ☐occasional ☐1/2 pack/day ☐1pack/day ☐1+pack/day

Name of your medical doctor _____

Thank you for trusting us to take care of your vision. As an office policy, payment is expected at the conclusion of your examination. By signing below, you authorize us to examine you (or your child if a minor) and you agree to be responsible for the payment of services and supplies.

Signature _____ Date _____

Physician's

Signature _____ Date _____

Southern EyeCare, P.C.

Signature on File Form/Notice of Privacy Practices

1. **NOTICE OF PRIVACY PRACTICES**: By signing this form below, I acknowledge I have been provided with the above practice's "Notice of Privacy Practices" to review, and informed that I may keep a copy for reference or obtain a copy upon request.

2. **MEDICARE**: I request that payment of authorized Medicare benefits be made on my behalf to Southern EyeCare, P.C. for services furnished my by Southern EyeCare, P.C.. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly 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 information is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Southern EyeCare, P.C. accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

3. **MEDIGAP**: I understand that if a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Southern EyeCare, P.C., if possible or otherwise to me.

4. **RELEASE OF INFORMATION**: Southern EyeCare, P.C. may disclose all or nay part of my medical record and /or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Southern EyeCare, P.C. for reimbursement for services rendered, and (2) any health care provider for continued patient care. Southern EyeCare, P.C. may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

5. **NON-COVERED SERVICES**: I understand that Southern EyeCare, P.C. contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service not to be covered. Examples of non-covered services include, but are not limited to, the REFRACTION FEE, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Southern EyeCare, P.C. to obtain necessary health care service plan authorizations.

SIGN AND DATE HERE:

Signed:_____ Date:_____

Patient Signature or Authorized Party and Date