

EYE ASSOCIATES OF CAYCE-WEST COLUMBIA

Drs. Efron, Kleckley, Henry & King

PATIENT INFORMATION

PLEASE PRINT & ANSWER ALL SECTIONS COMPLETELY

Patient Name _____ Home _____ Work _____
(Last) (First) (Middle) Tel _____ Tel _____

Address _____
Street City State Zip

Birth date _____ Age _____ Sex _____ Marital Status Married Single Other _____

Patient SS# _____ E-mail Address _____

Referring Dr. _____ How did you hear of us? MD/Family/Yellow Pages/Other _____

Employer _____ Occupation _____

Employer Address _____
Street City State Zip

Name of Spouse/Parent _____ Spouse/Parent's Employer _____ Tel _____

Emergency Contact _____
Name Telephone Relationship

RESPONSIBLE PARTY

Name _____ Self Parent Other _____

Address _____ Home Tel _____
Street City State Zip Bus. Tel _____

Employer _____ Address _____
Street City State Zip

INSURANCE INFORMATION

Primary Insurance _____ Secondary Insurance _____

Subscriber Name _____ Subscriber Name _____

SS# _____ DOB _____ Sex _____ SS# _____ DOB _____ Sex _____

Company _____ Company _____

Policy/Group# _____ Policy/Group# _____

Payment Method Cash Check Credit Card

Insurance coverage for your medical care is helpful since it reduces your potential liability, and we are glad to help you complete claim forms. However, the financial agreement rests with you and not the insurance company. I authorize the release of any medical or other information necessary to process my insurance claims. I authorize payment of medical benefits to Eye Associates of Cayce-West Columbia for services rendered.

Patient or authorized person's signature _____ Date _____

Receipt of Notice of Privacy Policies & Consent Form

Eye Associates of Cayce - West Columbia
600 Knox Abbott Drive Cayce, SC 29033
(803) 794-4444
(803) 794-2085 Fax

Patient Name: _____

Patient Number: _____ Patient Phone Number: _____

Patient Address: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices*. Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices*.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Eye Associates of Cayce - West Columbia.

Signature

Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient

Print Name

Source of Authority: _____

Medical History Questionnaire

Name: _____ Today's Date: ____ / ____ / ____

Address: _____ Phone: _____

Birth Date: ____ / ____ / ____ Social Security #: ____ / ____ / ____ Last Eye Exam: ____ / ____ / ____

Name of Medical Doctor: _____ Dr.'s Phone: _____

Last Medical Exam: ____ / ____ / ____

Medical History

Do you have any allergies to medications? no yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

List all major injuries, surgeries and/or hospitalizations you have had: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant and/or nursing? no yes

Do you wear glasses? no yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? no yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? yes no

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please turn this form over and complete side two

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? no yes If yes, do you have visual difficulty when driving? no yes If yes, please describe:

Do you use tobacco products? no yes If yes, type/amount/how long: _____

Do you drink alcohol? no yes If yes, type/amount/how long: _____

Do you use illegal drugs? no yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?		NO	YES	?
CONSTITUTIONAL							
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
NEUROLOGICAL							
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
EYES							
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
ENDOCRINE							
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
				EARS, NOSE, MOUTH, THROAT			
				Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				RESPIRATORY			
				Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				VASCULAR / CARDIOVASCULAR			
				Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				GASTROINTESTINAL			
				Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				GENITOURINARY			
				Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				BONES / JOINTS / MUSCLES			
				Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				LYMPHATIC / HEMATOLOGIC			
				Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				ALLERGIC / IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

Doctor's Signature _____

Date _____