# WELCOME TO HEART OF AMERICA EYE CARE

## PATIENT INFORMATION

Last Name_____ First Name _____ MI _____

Birth Date_____ Gender: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W

Address_____ City_____ State_____ Zip_____

Social Security #_____ Email*_____

Phone: ☐ HOME_____ ☐ CELL_____ ☐ WORK_____

*Check preferred contact number*

Race_____ Ethnicity: ☐ Hispanic/Latino ☐ Other ☐ Decline to answer

Primary Language: ☐ English ☐ Spanish ☐ Other _____

Primary Care Physician_____ Address_____ Phone_____

Preferred Pharmacy_____ Address_____

## EMERGENCY INFORMATION

Contact Name_____ Relationship_____

Phone: H C W (circle)_____ H C W (circle)_____

## PATIENT EMPLOYMENT INFORMATION

Employer_____ Occupation_____

Address_____ City_____ State_____ Zip_____

**How did you hear about us?** ☐ Internet ☐ Friend/family ☐ Doctor ☐ Other_____

With whom may we speak about financial statements, test results, or other services provided by our office regarding your medical treatment? *(circle all that apply)*

Spouse Parent Guardian Adult children Emergency Contact Other_____ **No one**

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments; however, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered, unless other arrangements have been made in advance.

**AUTHORIZATION**: I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to Heart of America Eye Care, P.A. for any services furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid services or its intermediaries or carriers any information needed for this or related to a Medicare/other insurance company claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the healthcare provider or any other party may be responsible for paying for my treatment.

*We may use your email address to send you appointment reminders or information about our practice and specials. However, we will not share your email address with any other person or organization.

☐ I acknowledge receipt of notice of privacy practices.
☐ I authorize Heart of America to view my prescription from external sources.
☐ I acknowledge that I have read and understand the office policies.

Patient Signature_____ Date_____

*Or signature of parent or legal guardian if patient is under 18 years of age.*

**Patients under 18 must have a parent/guardian present at exam OR written consent/Minor Consent Form.**

# HEART OF AMERICA EYE CARE

## Medical History

Name_____ Birth date_____ Today's date_____

Why are you here today?_____

**Circle "S" if <u>you</u> have the condition or "F" if a family member has the condition:**

**EYE**
- S F Cataracts
- S F Glaucoma
- S Dry eyes
- S F Macular degeneration
- S F Retinal tear/detachment
- S F Fuch's Dystrophy
- S F Lazy eye/strabismus
- S Prior LASIK/PRK/RK

**HEART**
- S F High blood pressure
- S F Coronary artery disease
- S F Congestive heart failure
- S F Irregular heart beat
- S Chest pain
- S Vascular problems

**RESPIRATORY**
- S Asthma
- S COPD/emphysema
- S Sleep apnea
- S Shortness of breath
- S Wheezing
- S Coughing

**ENDOCRINE**
- S F High cholesterol
- S Type I diabetes since _____
- S F Type 2 diabetes since _____
- S Thyroid disorder
- S F Grave's disease

**MUSCULOSKELETAL**
- S Arthritis
- S Joint pain
- S Muscle aches
- S Low back pain

**IMMUNOLOGIC**
- S F Rheumatoid arthritis
- S F Sjogren's syndrome
- S F Lupus
- S F Sarcoidosis
- S Juvenile rheumatoid arthritis
- S F Ankylosing spondylitis
- S F HLA-B27
- S F Myasthenia gravis

**EAR, NOSE, THROAT**
- S Seasonal allergies
- S Hearing loss
- S Sinus problems
- S Sore throat

**SKIN DISORDERS**
- S Rosacea
- S Eczema
- S Excessive dry skin

**GASTROINTESTINAL**
- S Acid reflux
- S Ulcers
- S Crohn's disease
- S Ulcerative colitis
- S Abdominal pain

**URINARY**
- S Enlarged prostate
- S Blood in urine
- S Excessive urination
- S Pain w/ urination

**NEUROLOGIC**
- S Depression
- S Anxiety
- S Headaches
- S Migraines
- S Numbness
- S Weakness
- S F Alzheimer's disease
- S Memory loss

**GENERAL HEALTH**
- S Fatigue
- S Unexpected weight loss/gain
- S Hepatitis
- S HIV/AIDS

**CANCER**
- S F Melanoma
- S Skin cancer
- S F _____
- S F _____

Other conditions not listed above_____

Eye medications/drops_____

Other medications (***or*** **attach list**)_____

_____

Allergies (medications, food, etc)_____

Eye surgeries_____

Major surgeries (with date); minor surgeries in last 5 years_____

_____

Do you smoke? Never Current Former _____ packs/day for _____ years (quit _____ yrs ago)

Do you drink alcohol? No Rare Yes _____ drinks per *(circle):* day week month

# HEART OF AMERICA EYE CARE, P.A.

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Brenda Edwards, OD · Laura Brammer, OD · Stephanie Erker, OD

Due to many changes with insurance plans and from healthcare reform, NOT all insurance plans cover a routine eye/vision exam. It is the responsibility of the insured to know the EXACT benefits of their insurance plan. You must inform us whether your visit will be a medical exam or a routine vision exam.

**NO CHANGES CAN BE MADE AFTER THE EXAM IS COMPLETED.**

☐ **MEDICAL** (i.e. diabetes, cataracts, glaucoma, red eye, floaters)

☐ **ROUTINE VISION** (i.e. glasses, contact lens evaluation)

**DO YOU HAVE A VISION PLAN? VSP Eyemed Spectera VCP**
*(circle)*

Primary Member_____

Birth Date_____ SSN_____

Please provide ALL of your insurance cards at your appointment.
We will file the insurance you designate and cannot re-file after your date of service.

_____ _____

Signature Date