Patient Demographic Review

Patient Name				Salutation	
DOB		Age		Birth State	
Sex				SS #	
Address					
Address Type				Country	

COMMUNICATION					
Preference					
Home Phone #		Work Phone #		Extension	
Cell Phone #		Carrier			
Email					

INFORMATION			
Plan Type		HIPAA Signed	
Primary Language		Special Needs	
Race		Ethnicity	
Marital Status		Mother's Maiden Name	
Occupation		Employer	

ACCOUNT RESPONSIBLE					
Responsible				Salutation	
Relationship				SS #	
Address					
Home Phone #		Work Phone #		Extension	
Email					

PRIMARY INSURANCE			
Name		Group Name	
ID #		Group #	
Address			
Phone		PAY %	
Insured		Date of Birth	

Copay	

SECONDARY INSURANCE			
Name		Group Name	
ID #		Group #	
Address			
Phone		PAY %	
Insured		Date of Birth	

EMERGENCY CONTACT										
Sal	First	MI	Last	Relation	Home#	Cell#	Work#	Ext	Organization	Title

OTHER CONTACTS										
Sal	First	MI	Last	Relation	Home#	Cell#	Work#	Ext	Organization	Title

RELEASE OF MEDICAL INFORMATION – STATUS				
	Relation		Release Status	

PATIENT MEDICAL HISTORY RECORD

DATE (MM/DD/YY) | REFERRED BY | BIRTH DATE

PATIENT'S NAME | SEX | AGE

ADDRESS | PHONE (H)

EMPLOYER | OCCUPATION | PHONE (W)

SOC SEC NO. | PRIMARY CARE PHYSICIAN

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc)?
   Yes ☐ No ☐ If YES, please explain: _____
2. Have YOU ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
   Yes ☐ No ☐ If YES, please explain: _____
3. Have you ever had any surgery?
   Yes ☐ No ☐ If YES, please provide date and reason _____
4. Have you ever been hospitalized?
   Yes ☐ No ☐ If YES, please provide date and reason _____
5. Do you take any medications?
   Yes ☐ No ☐ If YES, please list: _____
   Do you take any eye medications:
   Yes ☐ No ☐ If YES, please list: _____
6. Do you have any drug or food allergies?
   Yes ☐ No ☐ If YES, please list: _____

Review of Systems

Do you currently have any of the follow problems?

	Yes	No	If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)	☐	☐	
Heart problems (e.g. chest pain, irregular heart beat)	☐	☐	
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	☐	☐	
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	
Urinal problems (e.g. pain or discomfort, blood in urine)	☐	☐	
Skin problems (e.g. rashes, excessive dryness)	☐	☐	
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)	☐	☐	
Neurologic problems (e.g., numbness, weakness, headaches, paralysis)	☐	☐	
Psychiatric problems (e.g., depression, anxiety)	☐	☐	

Family and Social History

Do any medical or eye diseases run in your family (e.g., diabetes, high blood Pressure, cancer, glaucoma, mascular degeneration)?
Yes ☐ No ☐ If YES, please explain: _____

Do you smoke? If Yes, how much? ☐ Drink alcohol? If Yes, how much ☐

If employed, how many hours per week do you work? ☐

Comments _____

Signature _____ Date

Patient Name: _____
Account# _____
DOB: _____

Alpha Eye Associates, LLC

FINANCIAL ASSIGNMENT AND AGREEMENT

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charges. It is your responsibility to pay any deductible amount, co-insurance, or any other balance is paid by your insurance.

In order to control your cost of billing, we request that your charges for office visit be paid at the commencement of each visit. There is a $30.00 charge for returned checks.

I request that payment of authorized Medicare and or insurance benefits be made in my behalf for any services furnished to me. I authorize Alpha Eye Associates, LLC To release to the Health Care Financing Administration, its agents or any insurance carrier I may have any any information needed to determine theses benefits or the benefits for related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize Alpha Eye Associates, LLC to release all information necessary to secure the payment.

Signed: _____ Date: _____

Alpha Eye Associates, L.L.C.
3969 South Cobb Drive, Ste 105

Smyrna, Georgia 30080
770-434-9324
770-434-9364 fax

Acknowledgement Of Privacy Practices

I, acknowledge that I have received a copy of the Notice of Privacy Practices from Alpha Eye Associates, L.L.C..

I have listed individuals that are authorized to receive my protected health information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

Signature of Patient _____ Date _____

Signature of Patient Representative & Relationship _____ Date _____
(Required if patient is a minor or an adult unable to sign form)

The following individuals have my authorization to access my Protected Health Information

Name	Relationship	Date of Birth