THREE YEAR PATIENT MEDICAL HISTORY RECORD

Name: ______________________________ **Date:** ______________

PAST EYE HISTORY (List any diagnosed eye illness or surgeries) ______________________________
____

CURRENT EYE MEDICATIONS (List all eye drops or ointments) ______________________________
____

PAST MEDICAL HISTORY

	YES	NO		YES	NO
TUBERCULOSIS	____	____	HIGH BLOOD PRESSURE	____	____
CANCER	____	____	KIDNEY DISEASE	____	____
DIABETES	____	____	THYROID DISEASE	____	____
BLOOD DISORDERS	____	____	LUNG DISEASE	____	____
HEART DISEASE	____	____	NEUROLOGICAL DISORDERS	____	____

OTHER (DESCRIBE)______________________________
____

MAJOR SURGERIES (DESCRIBE)______________________________
____

MEDICATIONS (List all medications including Oral, Prescription, Topical, Injections, OTC, Vitamins, and Homeopathic/Herbal Medications)
____
____
____

ALLERGIES (List all known Drug, Substance, or Ocular allergies)______________________________
____

FAMILY HISTORY (Please list any family history of eye diseases or illnesses)______________________________
____

SOCIAL HISTORY

DO YOU SMOKE? ( ) YES ( ) NO HOW MUCH?______________________________
DO YOU DRINK ALCOHOL? ( ) YES ( ) NO HOW MUCH?______________________________
HAVE YOU EVER USED DRUGS? ( ) YES ( ) NO IF YES, EXPLAIN______________________________
HAVE YOU EVER HAD A BLOOD TRANSFUSION? ( ) YES ( ) NO

REVIEW OF SYSTEMS (Do you have any of the following problems? If so, please circle which one)

CHRONIC FEVER, UNEXPECTED WEIGHT LOSS/GAIN, FATIGUE ( ) YES ( ) NO ______________
EAR/NOSE/THROAT PROBLEMS (hearing loss, sinus problems, etc) ( ) YES ( ) NO ______________
HEART PROBLEMS (chest pain, irregular heart beat, etc) ( ) YES ( ) NO ______________
RESPIRATORY PROBLEMS (shortness of breath, wheezing, coughing) ( ) YES ( ) NO ______________
GASTROINTESTINAL PROBLEMS (heartburn, abdominal pain, etc) ( ) YES ( ) NO ______________
URINARY PROBLEMS (pain or discomfort, blood in urine, etc) ( ) YES ( ) NO ______________
SKIN PROBLEMS (rashes, excessive dryness, etc) ( ) YES ( ) NO ______________
MUSCULOSKELETAL PROBLEMS (muscle aches, joint pain, etc) ( ) YES ( ) NO ______________
NEUROLOGIC PROBLEMS (numbness, weakness, headaches, paralysis) ( ) YES ( ) NO ______________
PSYCHIATRIC PROBLEMS (depression, anxiety, etc) ( ) YES ( ) NO ______________
ALLERGIES (hay-fever, sinus problems, runny nose, etc) ( ) YES ( ) NO ______________

Completed By: ______________________________ Relationship: ______________

HISTORY REVIEWED ( ) CHANGES ( ) CHANGES AS NOTED - PHYSICIAN: ______________ DATE:__________

PATIENT INFORMATION

PATIENT NAME: ______________________________ (Last) ______________________________ (First) ____________ (MI)

ADDRESS: ______________________________ (Street/PO Box) ______________________________ (Apt #)

______________________________ (City) ______________________________ (State) ______________________________ (Zip)

HOME PHONE: ______________________________ CELL PHONE: ______________________________

PATIENT SEX: ( ) MALE ( ) FEMALE DATE OF BIRTH: ____________________ AGE: __________

MARITAL STATUS: ______________________________ SOCIAL SECURITY NO: ______________________________

EMPLOYER: ______________________________ EMAIL ADDRESS ______________________________

OCCUPATION: ______________________________ BUSINESS PHONE: ______________________________

REFERRING DOCTOR: ______________________________ PHONE: ______________________________

PRIMARY CARE DOCTOR: ______________________________ PHONE: ______________________________

CARDIOLOGIST: ______________________________ PHONE: ______________________________

PERSON TO NOTIFY IN AN EMERGENCY: ______________________________ (Name) ______________________________ (Phone)

PRIMARY INSURANCE INFORMATION

PLEASE FILL OUT COMPLETELY

INSURED'S NAME: ______________________________ DATE OF BIRTH: ______________________________

ADDRESS: ______________________________ CITY/STATE/ZIP: ______________________________

SOCIAL SECURITY NO: ______________________________ SEX: ( ) MALE ( ) FEMALE

EMPLOYER NAME/AND PHONE: ______________________________

OTHER INSURANCE INFORMATION

Do you have a separate vision carrier (i.e. VSP, Superior Vision, EyeMed, Vision Care Plan)? ☐ Yes ☐ No
If yes, please list plan name: ______________________________
Please Note: Many vision plans require a preauthorization that is unobtainable after the date of service. Therefore, if we do not have prior knowledge of your separate vision plan, we will not able to file a claim.

PLEASE BE ADVISED: INSURANCE CLAIMS ARE FILED AS A COURTESY FOR OUR PATIENTS. IT IS YOUR RESPONSIBILITY TO KNOW THE SPECIFICS OF YOUR PLAN. PLEASE CONTACT YOUR INSURANCE COMPANY PRIOR TO YOUR VISIT TO: VERIFY THE PHYSICIAN IS A PARTICIPATING PROVIDER, CHECK REFERRAL STATUS (IF REQUIRED), OR IF YOU HAVE MET DEDUCTIBLES.

Assignment and Release: I hereby authorize my insurance benefits be paid directly to the physician and acknowledge that I am financially responsible for any noncovered services or unpaid balance and any legal fees necessary to collect the unpaid balance. I also authorize my physician to release any information required in processing these benefits.

DESIGNATED HIPAA RELEASE & COMMUNICATION

At my request, I authorize Georgia Eye Physicians & Surgeons to disclose my protected health information to:

Name: ______________________________ Relationship ______________________________ Phone ______________________________

Name: ______________________________ Relationship ______________________________ Phone ______________________________

PATIENT SIGNATURE: ______________________________ DATE: ______________________________

GEORGIA EYE PHYSICIANS AND SURGEONS
WILLIAM A. SEGAL, MD

CONTACT LENS EXAM CHARGES, FITTING FEES, AND AGREEMENT

	EXISTING WEARER	FIRST TIME WEARER
SOFT SPHERICAL	$50.00	$75.00
SOFT TORIC/COLORS	$100.00	$125.00
SOFT BIFOCAL/MONOVISION	$100.00	$125.00
GAS PERMEABLE SPHERICAL	$125.00	150.00
GAS PERMEABLE KERATOCONUS/CUSTOM/BIFOCAL	$250.00 or more NON REFUNDABLE	$250.00 or more NON REFUNDABLE

THE FITTING FEE INCLUDES:

1. A health examination of the eyes.
2. An instruction session on how to insert and remove your contact lenses (first time wearer) and instructions on the proper care of the lenses.
3. Continuing contact lens wears are required to return yearly to insure that your contact lenses are still properly fitting and providing you with the highest quality vision, comfort and health. There is an annual contact lens examination fee.
4. Soft contact lens fittings include the following:
   a.) One no-charge follow-up visit within 30 days to check the contact lens fit.
   b.) After one no-charge follow-up visit the charge is $30.00 for each of the next 2 visits within 30 days.
   c.) After 30 days the charge is $40.00 for each of the next 2 visits.
5. Gas permeable/Keratoconus contact lens fittings **not covered by insurance** include the following....
   a.) Three no-charge follow-up visits
   b.) After three no-charge follow-up visits the charge is $50.00 for each additional visit.
   c.) RGP/ Keratoconus contact lens wears must purchase their contacts from Georgia Eye Physicians and Surgeons.
6. Payment for all contact lens services is required at the time of service. Payment for the contact lenses may be required before the prescription is finalized.
7. All fees should be paid in full prior to any contact lens fittings for medically necessary Keratoconus contact lens/scleral contact lens. You may file with your insurance carrier for reimbursement. Any overpayments made by your insurance carrier will be refunded to you upon receipt of payment from your insurance carrier. A scleral lens may receive a partial material refund within 60 days of initial lens order minus a nominal restocking fee, after which time no refund will be given.
8. It is not always possible to determine in advance whether a person will become a successful wearer. There are no guarantees and the exam and contact lens fitting fees are not refundable for any reason.

PATIENT RESPONSIBILITY

It is the patient's responsibility to pay the contact lens fitting fee in addition to the contact lenses. Contacts purchased may be exchanged for merchandise of equal or lesser value. No refunds after orders are placed and we are unable to exchange contact lens boxes if opened or written on.

CHECK ONE

☐ I want contact lenses today.

☐ I do not want contact lenses today.

Signature: ______________________________ Date: ______________

Full Printed Name: ______________________________