MONTGOMERY LASIK & EYE CARE CENTER

PERSONAL INFORMATION

☐ Male ☐ Female

Last Name | First Name | MI | ☐ Single ☐ Married ☐ Divorced ☐ Widow

Street Address | City | State | Zip

(____)____ Home Phone | (____)____ Cell Phone | ____/____/____ Date of Birth | ___-___-____ Social Security Number

Employer/Name of School (if student) | Occupation | (____)____ Work Phone

E-mail Address | Spouse or Parent(s) Name | DOB

Person Responsible for Account | Social Security # of Person Responsible for Account

Address of Person Responsible for Account | (____)____ Telephone #

Emergency Contact | (____)____ Emergency Phone

How were you referred to our office? ☐ Phone Book ☐ Radio ☐ Insurance listing ☐ LED Sign (outside) ☐ Patient ☐ Other____

☐ Doctor____ Address____

INSURANCE INFORMATION

Name of Primary Medical Insurance Company | Address | (____)____ Telephone #

Insured's Last Name | Insured's First Name | MI | Insured's Date of Birth

Insured's Identification Number | Group Number | Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Secondary Medical Insurance Company | Address | (____)____ Telephone #

Insured's First Name | MI | Insured's Last Name | Insured's Date of Birth

Insured's Identification Number | Group Number | Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

VISION Insurance Company Name | I.D. # & Insured's Social Security #

Please Read: (1) All professional services rendered are charged to the patient (2) All health insurance information must be presented to file claims. (3) The patient is responsible for prior authorization or other requirements regarding any insurance coverage. (4) There may be services such as refraction which are not covered by insurance. (5) All payments are due at the time services are rendered. (6) I, the undersigned, accept the fees charged for medical services rendered and/or products sold, as a legal and lawful debt and agree to pay said fees, including any all costs of collection, (33.33%), attorney fees and or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the state of Alabama and any other state. (7) I, the undersigned, give Montgomery Lasik and Eye Care Center, its employees and or agents "express prior consent" to contact me at any all phone numbers, including cell phone numbers (by phone call or text message), for the purpose of treatment, insurance and/or payment. I acknowledge that I have received, read and understood the HIPAA privacy policies of Montgomery Lasik and Eye Care Center. I understand that the physicians and staff of Montgomery Lasik and Eye Care Center will not discuss my health information to anyone other than allowed by the HIPAA privacy policies or unless I have authorized them to do so. I hereby consent that medical information and test results can be discussed with the following persons.

Name | Relationship | (____)____ Telephone #

Signature / Patient or Parent/Guardian (if minor)

PATIENT HEALTH HISTORY QUESTIONNAIRE

Please answer all questions.

NAME: _____ Today's Date: _____

AGE: _____ DATE OF BIRTH: _____

MEDICAL INFORMATION

Do you have problems with any of these systems? (Please **circle yes or no.)**

DIABETES	Yes / No	GASTROINTESTINAL	Yes / No
HIGH BLOOD PRESSURE	Yes / No	EARS/NOSE/THROAT	Yes / No
HEART DISEASE	Yes / No	CARDIOVASCULAR	Yes / No
ARTHRITIS	Yes / No	RESPIRTORY	Yes / No
CANCER	Yes / No	GENITOURINARY	Yes / No
DERMATOLOGIC	Yes / No	KIDNEY STONES	Yes / No
STEROID USE	Yes / No	BLOOD/LYMPH	Yes / No
HEADACHES	Yes / No	OTHER ILLNESS	Yes / No
PREGNANT OR NURSING	Yes / No		

Allergies to Medications: Yes / No Please List: _____

_____

Current medications please List: _____

_____

Eye Medications: _____

Do you use Alcohol? Yes / No How much in one week? _____

Do you use Tobacco? Yes / No How much in one week? _____

FAMILY HISTORY

High blood pressure	Yes / No	Relation_____
Diabetes	Yes / No	Relation_____
Macular degeneration	Yes / No	Relation_____
Glaucoma	Yes / No	Relation_____
Retinal detachment	Yes / No	Relation_____
Cataracts	Yes / No	Relation_____
Blindness	Yes / No	Relation_____
Other	Yes / No	Relation_____

PERSONAL EYE HISTORY

Have you had any eye injury? Yes / No What Kind?_____ Date_____

Have you had any eye operations? Yes/No What Kind? _____ Date_____

(Please circle.)

Do you have Glaucoma? Cataracts? Retinal detachment? Macular degeneration?

Dry Eyes? Blurred Vision? Lazy Eye/Crossed Eye

Do you wear glasses? Yes/No Do you wear Contacts? Yes/No

UPDATED _____

UPDATED _____