MONTGOMERY LASIK & EYE CARE CENTER

2080 BERRYHILL ROAD MONTGOMERY, AL 36117

(334) 387-2020

PATIENT NAME: _____

D.O.B.: _____

PRIMARY TELEPHONE: ( ) _____

EMAIL: _____

PLEASE READ: (1) All Doctor's services are charged to the patient. (2) **Both medical and vision insurance information must be presented in order to file insurance claims.** (3) The patient is responsible for prior authorizations or other requirements regarding any insurance coverage. (4) There may be services, such as a refraction, which are not covered by insurance. (5) Insurance eligibility is NOT a guarantee of payment. (6) **ALL payments are due at the time services are rendered. (7) If the doctor should discover any medical issues, it would fall under medical insurance and the patient is responsible for that co-pay.** (8) I, the undersigned, accept the fee 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 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. You agree, in order for us to service your account or to collect monies you may owe, Montgomery LASIK & Eye Care Center and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and/or our agents may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. (9) We have read this disclosure and agree that Montgomery LASIK & Eye Care Center, its employees, and/or agents, may contact me/us by any permissible method described above. You agree that any permissible contact may include the use of pre-recorded and/or artificial voice messages and/or the use of an automatic telephone dialing system.

_____

Signature (Patient or Parent/Guardian if a minor) DATE

HIPAA ACKNOWLEDGEMENT

I acknowledge that I have received, read, and understand the HIPAA privacy policies of Montgomery Lasik & Eye Care Center. I understand that the physicians and staff of Montgomery Lasik & Eye Care Center will not discuss my health information to anyone other than what is allowed by the HIPAA privacy policies 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 Phone Number Date

_____ (____) _____

Name Phone Number Date

_____

Signature (Patient or Parent/Guardian if a minor) DATE

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*

_____ _____ Patient Relationship to Insured

Insured's Identification Number *Group Number* ☐ 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*

_____ _____ Patient Relationship to Insured

Insured's Identification Number *Group Number* ☐ Self ☐ Spouse ☐ Child ☐ Other

_____ _____

Vision Insurance Company Name Insured's Social Security #

_____

Signature (Patient or Parent/Guardian if minor) Date

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.**)

		Pregnant/Nursing	Yes/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

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 _____