Patient ID: _____ **Conway Ophthalmology Associates** Appointment: _____

1405 Main Street, Suite B, Conway, SC 29526

***P**: (843) 488-7730 **F**: (843) 488-5188*

Patient Information Form

PLEASE COMPLETE EACH SECTION BELOW

Have you been to Conway Ophthalmology within the past 3 years? **Yes / No**

Patient's Legal Name: _____ Preferred Name: _____

Date of Birth: ____ /____ /_____ Age: ____ SSN: _____-____-_____ Sex: **M / F** Marital Status: **M / S / D / W**

Race/Ethnicity: _____ Employer: _____ Occupation: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ May we text you? **Yes / No**

Mailing Address: _____ _____ ____ _____
City *State* *Zip Code*

Responsible Person (if patient is a minor or legally dependent)

Name: _____ Date of Birth: ____ /____ /_____ Relation: _____

Emergency Contact

Name: _____ Phone Number: _____

Address: _____ _____ ____ _____
City *State* *Zip Code*

Insurance

Primary Insurance Policy Name: _____

Relationship to Policyholder: Self / Spouse / Child / Other_____ Employer: _____

Policyholder's Name: _____ Policyholder's Date of Birth: _____ Policyholder's SSN: _____
(If other than yourself)

Secondary Insurance Policy Name: _____

Relationship to Policyholder: **Self / Spouse / Child / Other**_____ Employer: _____

Policyholder's Name: _____ Policyholder's Date of Birth: _____ Policyholder's SSN: _____
(If other than yourself)

Reason for today's visit: _____

Payment Authorization: Although covered by my insurance, I am aware that I am personally responsible for all co-payments, co-insurance, deductibles, and any services not covered by my insurance at the time of service. I understand I may be billed later for services rendered if determined by my insurance company that I am responsible. A photocopy of this authorization will be as valid as the original.

Consent for Treatment: I am granting consent for me, or my legal dependent stated above to receive medical or vision care. I understand that only care relevant to my present illness may be treated, and that the ophthalmologist may recommend further or additional care.

Patient or Guardian Signature: _____ **Date**: _____

Acknowledgement of Receipt of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices adhered to by *Conway Ophthalmology Associates* detailing how my health information may be used and disclosed as permitted under federal law and outlining my rights regarding health information. By signing below, I acknowledged, and I was given/offered a copy of the Notice of Privacy Practices and consider myself informed.

Signature: _____ **Date**: _____

Relationship to patient if other than self: _____

Do you want to designate a family member or other individual with whom the provider may discuss your medical condition? If yes, whom?

Name(s): _____

May we discuss via phone? Yes or No
May we leave a message? Yes or No
May we fax the information? Yes or No *if yes, list the phone/fax numbers*: _____

Internal Use Only: If the patient/patient's representative refuses to sign the acknowledgement, please document the date and time the notice was presented to the patient and sign below.

Presented on (time & date): _____ By (name & title): _____

RELEASE OF INFORMATION AND SIGNED CONSENT

INSURANCE LIABILITY AND FINANCIAL RESPONSIBILITY

As part of our effort to provide outstanding services we will make every attempt to file your medical claim. Please note you are ultimately responsible for fees associated with your care. The payment of Co-Pays, Co-Insurance, Deductibles, and all other non-covered items or services, if not otherwise insured, are expected at the time of service. YOU MAY BE BILLED FOR SERVICES RENDERED IF IT IS DETERMINED BY YOUR INSURANCE COMPANY THAT YOU ARE FINANCIALY RESPONSIBLE.

Occasionally, your insurance company, this office, or a covered entity designated by healthcare law may review your claims or record and determine at a later date that you were financially responsible for past date of service.

Your signature below also acknowledges that in filing any claim on your behalf, your records may be requested by your insurance company in aid or payment. You understand that your records contain Protected Health Information and may contain information from referring providers, HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, and sexually transmitted diseases, as well as additional medical, mental, and physical ailments.

WE CANNOT FILE YOUR CLAIM WITHOUT YOUR CONSENT

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY AND PERMISSION TO FILE MEDICAL CLAIMS

Medical History

Name: _____ Date of Birth (MM/DD/YYYY): ____ /____ /____

Ocular and General Medical History *Please indicate the year in which you were diagnosed*

	Year		Year		Year
☐ Trauma to Eye/Face	_____	☐ Cataracts	_____	☐ Kidney Problems	_____
☐ Dry Eye	_____	☐ Hypertension	_____	☐ HIV Positive	_____
☐ Diabetic Eye Disease	_____	☐ Diabetes	_____	☐ Cancer	_____
☐ Iritis	_____	☐ Heart Attack	_____	☐ Stroke	_____
☐ Macular Degeneration	_____	☐ High Cholesterol	_____	☐ Arthritis	_____
☐ Glaucoma	_____	☐ Thyroid Disease	_____	☐ Autoimmune Dis.	_____
☐ Migraines	_____	☐ Lung Problems	_____	☐ Seasonal Allergies	_____

Other medical or ocular problems not listed: _____

_____

Previous eye surgeries (include which eye): _____

_____

Eye medications (include which eye): _____

_____

Previous surgeries (other than eye): _____

_____

Drug allergies: _____

_____

Physician's Name: _____ **Phone Number**: _____

Pharmacy Name: _____ **Phone Number**: _____

Social History

Smoking: How many packs a day do you smoke? _____ For how many years? _____ ☐ I Quit

Alcohol: How many alcoholic drinks do you consume a week? _____

Drug Use: Do you currently use or have a history of using illegal drugs? _____

Family History *Does anyone in you family have any of the following conditions? If so, who?*

☐ Macular Degeneration	_____	☐ Heart Disease	_____
☐ Glaucoma	_____	☐ Stroke	_____
☐ Lazy Eye	_____	☐ Cancer	_____
☐ Retinal Detachment	_____	☐ Diabetes	_____
☐ Iritis	_____		

Medication History

PLEASE LIST ANY CURRENT MEDICATIONS YOU ARE TAKING

Medication	*Dose*	*Frequency*

The information above is accurate to the best of my knowledge.

Patient or Guardian Signature: _____ **Date**: _____