EYE CARE CENTER ASSOCIATES, P.A. PATIENT INFORMATION

PLEASE COMPLETE FRONT AND BACK, SIGN & RETURN TO RECEPTIONIST

CHART NUMBER

DATE ____________________

PATIENT NAME: ______________________________ Male Female (Circle One)
last first middle

SS# ______________________ BIRTHDATE ____/______/______ AGE: ______

ADDRESS ______________________________
Mailing address city state zip code

HOME PHONE ____________________ CELL PHONE ____________________

EMPLOYED BY: ____________________ PHONE ____________________

ADDRESS ______________________________
Street address city state zip code

MARITAL STATUS MARRIED SINGLE DIVORCED SEPARATED WIDOW/ER MINOR (Circle One)

SPOUSE OR PARENT ______________________________ Male Female (Circle One)
last first middle

ADDRESS: ______________________________
Mailing address city state zip code

SOCIAL SECURITY # ____________________ PHONE# ____________________ BIRTHDATE ____/____/____

EMPLOYED BY: ____________________ PHONE # ____________________

ADDRESS: ______________________________
Street address city state zip code

EMERGENCY CONTACT: LOCAL FRIEND OR RELATIVE ______________________________
(Outside of home) Name phone

WHO REFERRED YOU TO THIS OFFICE? ______________________________

PATIENT INFORMATION:

WHO IS RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT?

PATIENT PARENT, IF PATIENT UNDER 18 YEARS OF AGE EMPLOYER IF WORK-RELATED INJURY
(Parent bringing child is responsible)

IF SOMEONE ELSE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, PLEASE COMPLETE THIS SECTION:

______________________________ Male Female SS# ____________________
LAST FIRST MIDDLE (Circle One)

PHONE: ____________________ RELATIONSHIP TO PATIENT: ____________________ BIRTHDATE: ____/____/____

ADDRESS: ______________________________
Mailing address city state zip code

EMPLOYED BY: ____________________ PHONE: ____________________

ADDRESS: ______________________________
Street address city state zip code

SIGNATURE OF RESPONSIBLE PARTY: ______________________________

IF INJURY, INDICATE DATE OF INJURY: ______/______/______ AND LOCATION ______________

PLEASE READ AND SIGN BACK OF FORM FOR INSURANCE/PAYMENT INFORMATION

INSURANCE

PLEASE PRESENT YOUR INSURANCE CARDS TO THE RECEPTIONIST BEFORE BEING SEEN.
(IF AT ANY TIME YOUR INSURANCE COVERAGE CHANGES, OR THEIR ADDRESS CHANGES PLEASE CONTACT OUR OFFICE WITH THAT INFORMATION. FAILURE TO DO SO MAY RESULT IN AN UNBILLABLE CLAIM TO INSURANCE.)

PLEASE BE AWARE THAT CHARGES ARE MADE TO THE PATIENT. FILING OF INSURANCE IS DONE AS A COURTESY. ALL BALANCES NOT PAID BY INSURANCE ARE DUE FROM THE PATIENT OR RESPONSIBLE PARTY NO LATE THAN **NINETY (90) DAYS** BEYOND THE DATE SERVICES ARE RENDERED. PATIENTS ARE RESPONSIBLE FOR THEIR PORTION OF COPAYS, DEDUCTIBLES, COINSURANCES, AND NON-COVERED SERVICES ON THE DATE SERVICES ARE RENDERED. FAILURE TO PAY ANY PORTION DEEMED AS INSURED RESPONSIBILITY BREAKS THE AGREEMENT YOU HAVE MADE WITH YOUR INSURANCE COMPANY AND MAY RESULT IN YOUR INSURANCE TERMINATING COVERAGE.

EYE CARE CENTER WILL FILE **MEDICARE, TRI-CARE,** AND **SOME, BUT NOT ALL** COMMERCIAL INSURANCE. PLEASE CHECK YOUR HANDBOOK OR CALL YOUR INSURANCE COMPANY IF THERE ARE QUESTIONS REGARDING BENEFITS OR PHYSICIAN PARTICIPATION IN YOUR INSURANCE NETWORK.

REFERRALS: IF YOUR POLICY REQUIRES A REFERRAL, PLEASE PRESENT IT TO THE RECEPTIONIST BEFORE BEING SEEN. IF A REFERRAL IS NOT OBTAINED PRIOR TO YOUR APPOINTMENT, PAYMENT IS DUE ON DATE SERVICE IS RENDERED AND INSURANCE CANNOT BE FILED. YOU ARE ALWAYS WELCOME TO RESCHEDULE YOUR APPOINTMENT WHEN REFERRAL IS OBTAINED.

TENN CARE

EYE CARE CENTER CURRENTLY FILES BlueCare and TN Care select.

AGREEMENT FOR NON-COVERED SERVICES:

CERTAIN SERVICES ARE NOT COVERED BY MEDICARE. THESE INCLUDE:

REFRACTION $25.00 SIGNED:______________________________

I, the undersigned, assign directly to EYE CARE CENTER ASSOCIATES, P.A. all vision, surgical, and/or medical benefits to be paid directly to the EYE CARE CENTER ASSOCIATES, P.A. on my behalf. I request that payment of any authorized medigap benefit be paid directly to EYE CARE CENTER ASSOCIATES, P.A. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize EYE CARE CENTER ASSOCIATES, P.A. to release all medical information necessary to secure the payment of benefits. I further authorize any holder of medical information about me to release to EYE CARE CENTER ASSOCIATES, P.A. any information needed to determine these benefits.

DATE: ____/_____/______ **SIGNED:**____

DATE: ____/_____/______ **WITNESSED:** ______________________________________

I HAVE READ AND AGREE TO ALL THE ABOVE-MENTIONED TERMS

SIGNATURE:____ **DATE:**____________________

Eye Care Center Associates
1100 North Jackson Street
Tullahoma, TN 37388

I, ________________, give my authorization to my physician/physicians staff to discuss any medical issues concerning me to:

____Spouse ___Son/Daughter/Children ___Caregiver ___Other______________

Please check all that apply:

___I give my physician/physician's staff permission to leave a message on my home answering machine or to any person answering my home phone.
___I give my permission to my physician/physician's staff to contact me at my place of employment. If I am unable to be reached there, I give permission to my physician/Physician's staff to leave a message for me to return their call.
___I give my permission to my physician/physician's staff to fax or discuss any information regarding me to another physician/physician's office that maybe covering for my physician/physician's staff, or a physician I may be referred to by my physician/physician's staff.
If there is any medical information I do not want to be discussed or a message left at my home or at my place of employment, I will notify my physician/physician's staff of this in writing. If there is any change in information pertaining to this consent, I will also notify my physician/physician's staff of this in writing.

For your privacy, anyone you have given us permission to speak with we will ask them to verify your date of birth.

____
Signature and Date

____
Witness (Office Staff Member)

Office Use Only:

____
Date of Birth

NAME________________________________ OCCUPATION________________________________ DATE________

Work: Are you in contact with any solvents, liquids, dyes, etc. YES NO

Smoke	Yes	No	How many packs per day________________	How many years__________
Alcohol	Yes	No	How much per day________________	
Caffeine	Yes	No	How much per day________________	

(1) Personal Medical History

Dizziness	Yes	No	Seasonal allergies	Yes	No
Glaucoma / eye problems	Yes	No	Other allergies	Yes	No
Ear /nose /throat /mouth	Yes	No	HIV /hepatitis /TB	Yes	No
HBP / heart problems	Yes	No	Skin problems	Yes	No
Blood / plasma transfusion	Yes	No	Neurological	Yes	No
Asthma / emphysema	Yes	No	Endocrine problems	Yes	No
Gallbladder disease	Yes	No	Gastro-intestinal	Yes	No
Arthritis / rheumatism	Yes	No	Cancer	Yes	No
Diabetes	Yes	No			

(2) Family History

Glaucoma	Yes	No
Cancer	Yes	No
Diabetes	Yes	No
HBP / heart problems	Yes	No
Stroke	Yes	No

(3) Family Doctor

(4) Medicines currently taking

(5) Eye drops currently using

(6) Allergies to medications

(7) Surgical History