# STEP 1 • PATIENT INFORMATION

**Please complete the FRONT AND BACK of each page**

## Register Online at: eyegroupms.com

Date _____

Last Name _____ First Name _____ MI _____

Address _____ City _____ State ____ Zip _____

Phone: Home (____) _____ Work (____) _____ Cell (____) _____

SS# _____ Date of Birth _____ Age _____

E-Mail Address _____ Gender [ ] Male [ ] Female

**Marital Status** [ ] Married [ ] Single [ ] Widowed [ ] Divorced [ ] Separated

**Ethnicity** [ ] Hispanic/Latino [ ] Not Hispanic/Latino

**Preferred Language** [ ] English [ ] Spanish [ ] Other _____

**Race** [ ] White [ ] Black/African American [ ] Asian [ ] American Indian/Alaska Native
[ ] Native Hawaiian/Pacific Islander [ ] Other _____

Employer _____ Occupation _____

Employer Address _____

Spouse's Name _____ Date of Birth _____ SS# _____

Spouse's Employer _____ Work (___) _____ Cell (___) _____

Emergency Contact Person _____ Phone (___) _____

**Referred By** [ ] TV [ ] Radio [ ] Yellow Page [ ] Insurance [ ] Website [ ] Brochure [ ] Self [ ] Magazine
[ ] Family [ ] Friend [ ] Patient [ ] Physician Name of Friend, Patient, or Physician: _____

**Preferred Communication Method** [ ] Mail [ ] Phone [ ] Text Message [ ] Email

(Eye Group will primarily use your preferred method of communication but may occasionally use texting and other methods you provide.)

**Please Complete If Patient is Under 18 Years of Age**

Mother's Last Name _____ First Name _____ MI _____

SS# _____ Date of Birth _____

Mother's Employer _____ Work (___) _____ Cell (___) _____

Address (If Different from Above) _____

Father's Last Name _____ First Name _____ MI _____

SS# _____ Date of Birth _____

Father's Employer _____ Work (___) _____ Cell (___) _____

Address (If Different from Above) _____



# STEP 1 • PATIENT INFORMATION

**Preferred Pharmacy Information**

Pharmacy Name _____ Pharmacy Phone _____

Address _____ City _____ State _____ Zip_____

**Primary Insurance** _____ Policy # _____

Address _____ Group # _____

**NOTE: IF THE POLICY IS IN THE NAME OTHER THAN PATIENT PLEASE COMPLETE THE FOLLOWING INFORMATION:**

Subscriber/Owner _____ Relation to Patient _____

SS# _____ Date of Birth _____

Address _____ City _____ State _____ Zip_____

**Secondary Insurance** _____ Policy # _____

Address _____ Group # _____

Subscriber/Owner _____ Relation to Patient _____

SS# _____ Date of Birth _____

Address _____ City _____ State _____ Zip_____

## PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our **Notice of Privacy Practices** provides information about how we may use and disclose protected health information about you. You have the right to review our Notice of Privacy Practices before signing this acknowledgement. Please review on our website at www.EyeGroupms.com.

A copy of our **Patient Rights and Responsibilities** will be provided to you at your first visit. It explains your rights as a patient in the event that an in office or surgical procedure is to be performed. If you would like to review prior to your appointment, you may do so on our website at www.EyeGroupms.com.

As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by requesting a copy in writing from: Privacy Officer, Eye Group, 501 Baptist Drive, Suite 220, Madison, MS 39110.

By signing this form, you acknowledge that you have reviewed our **Notice of Privacy Practices** and our **Patient Rights and Responsibilities,** and have no further questions regarding these forms.

**Patient or Responsible Party Signature** _____ **Date**_____



Eye GROUP

# STEP 1 • PATIENT INFORMATION

**Please complete the FRONT AND BACK of each page**

Patient Name _____ Date of Birth _____ Date _____

## RECORD OF MEDICAL CARE PATIENT HISTORY QUESTIONNAIRE

## PAST HISTORY

**INSTRUCTIONS: Please answer the following questions about your medical status and history.**

Birth Date: ____/____/____ Last Medical Exam: ____/____/____ Last Eye Exam:____/____/____

Name of Medical Doctor: _____ Medical Doctor's Phone (____) _____

List any medical conditions (i.e., high blood pressure, diabetes, etc.) that you have had in the past or are currently experiencing. _____

_____

_____

## Please complete the attached Medication List form.

Are you currently pregnant or nursing? [ ] Yes [ ] No

**Have you ever taken** Flomax or generic Flomax (Tamsulosin, Rapiflo)? [ ] Yes [ ] No

Do you currently wear Contact Lenses? [ ] Yes [ ] No Have you ever worn Contact Lenses? [ ] Yes [ ] No
If yes, please list Brand and Strength/power_____

**Please bring any eyeglasses or sunglasses that you routinely wear to your visit.**

List all major injuries, surgeries, heart attacks, strokes, and/or hospitalizations you have had:
(Include EYE Surgery, Laser, Injury) [ ] None [ ] Yes _____

_____

_____

Mark any of the following that you have / had: [ ] None [ ] Crossed eyes [ ] Lazy eye [ ] Drooping eyelid
[ ] Glaucoma [ ] Prominent eyes [ ] Retinal disease or detachment [ ] Cataracts [ ] Eye infection
[ ] Eye injury [ ] Other _____



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# STEP 1 • PATIENT INFORMATION

Patient Name _____ Date of Birth _____ Date _____

## REVIEW OF SYSTEMS

**INSTRUCTIONS: Do you currently or have you had any problems in the following areas? (IF YES, please explain.)**

| Neurologic | | Explain | |
|---|---|---|---|
| Headaches | [ ] Yes | _____ | [ ] No |
| Stroke | [ ] Yes | _____ | [ ] No |

| Eyes | | Explain | |
|---|---|---|---|
| Loss of vision | [ ] Yes | _____ | [ ] No |
| Distorted vision | [ ] Yes | _____ | [ ] No |
| Loss of side vision | [ ] Yes | _____ | [ ] No |
| Double vision | [ ] Yes | _____ | [ ] No |
| Dryness | [ ] Yes | _____ | [ ] No |
| Itching | [ ] Yes | _____ | [ ] No |
| Foreign body | [ ] Yes | _____ | [ ] No |
| Eye pain/soreness | [ ] Yes | _____ | [ ] No |
| Seeing flashes | [ ] Yes | _____ | [ ] No |
| Chronic Infections | [ ] Yes | _____ | [ ] No |

| Ear, Nose, Mouth & Throat | | Explain | |
|---|---|---|---|
| Allergies | [ ] Yes | _____ | [ ] No |
| Sinus Congestion | [ ] Yes | _____ | [ ] No |
| Dry mouth/throat | [ ] Yes | _____ | [ ] No |
| Chronic Cough | [ ] Yes | _____ | [ ] No |
| Hearing Loss | [ ] Yes | _____ | [ ] No |

| Respiratory | | Explain | |
|---|---|---|---|
| Asthma | [ ] Yes | _____ | [ ] No |
| Emphysema | [ ] Yes | _____ | [ ] No |
| Sleep Apnea | [ ] Yes | _____ | [ ] No |
| CPAP/BiPAP | [ ] Yes | _____ | [ ] No |

| Cardiovascular | | Explain | |
|---|---|---|---|
| High blood pressure | [ ] Yes | _____ | [ ] No |
| History Heart Attack | [ ] Yes | _____ | [ ] No |
| Pacemaker | [ ] Yes | _____ | [ ] No |
| Defibrillator | [ ] Yes | _____ | [ ] No |
| Taking Blood Thinner | [ ] Yes | _____ | [ ] No |

| Other | | | |
|---|---|---|---|
| History of Hepatitis | [ ] Yes | _____ | [ ] No |
| HIV/AIDS | [ ] Yes | _____ | [ ] No |
| Shingles | [ ] Yes | _____ | [ ] No |

| Neurologic | | Explain | |
|---|---|---|---|
| Migraine | [ ] Yes | _____ | [ ] No |
| Ocular migraine | [ ] Yes | _____ | [ ] No |

| Eyes | | Explain | |
|---|---|---|---|
| Blurred vision | [ ] Yes | _____ | [ ] No |
| Halos/glare | [ ] Yes | _____ | [ ] No |
| Loss of central vision | [ ] Yes | _____ | [ ] No |
| Mucous discharge | [ ] Yes | _____ | [ ] No |
| Sandy/gritty | [ ] Yes | _____ | [ ] No |
| Burning | [ ] Yes | _____ | [ ] No |
| Excess tearing | [ ] Yes | _____ | [ ] No |
| Redness | [ ] Yes | _____ | [ ] No |
| Tired eyes | [ ] Yes | _____ | [ ] No |
| Stye/Chalazion | [ ] Yes | _____ | [ ] No |

| Cancer/Other | | Explain | |
|---|---|---|---|
| BPH (Benign Prostate Hyperplasia) | [ ] Yes | _____ | [ ] No |
| Prostate Cancer | [ ] Yes | _____ | [ ] No |
| Breast Cancer | [ ] Yes | _____ | [ ] No |
| Other Cancer | [ ] Yes | _____ | [ ] No |
| Chemotherapy/ Radiation/Tamoxifen | [ ] Yes | _____ | [ ] No |

| Bones/Joints/Muscles | | Explain | |
|---|---|---|---|
| Osteoarthritis (age-related) | [ ] Yes | _____ | [ ] No |
| Rheumatoid Arthritis (autoimmune) | [ ] Yes | _____ | [ ] No |
| Restless Legs | [ ] Yes | _____ | [ ] No |

| Lymphatic/Hematologic | | Explain | |
|---|---|---|---|
| Anemia | [ ] Yes | _____ | [ ] No |
| Bleeding | [ ] Yes | _____ | [ ] No |

| Endocrine | | Explain | |
|---|---|---|---|
| Thyroid/other glands | [ ] Yes | _____ | [ ] No |
| Diabetes | [ ] Yes | _____ | [ ] No |
| High Cholesterol | [ ] Yes | _____ | [ ] No |



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**Please complete the FRONT AND BACK of each page**

Patient Name _____ Date of Birth _____ Date _____

## REVIEW OF SYSTEMS (continued)

**INSTRUCTIONS: Do you currently or have you had any problems in the following areas? (IF YES, please explain.)**

| Psychiatric | | Explain | | Psychiatric | | Explain | |
|---|---|---|---|---|---|---|---|
| Depression | [ ] Yes | _____ | [ ] No | Anxiety | [ ] Yes | _____ | [ ] No |
| ADD/ADHD | [ ] Yes | _____ | [ ] No | Dementia/Alzheimer's | [ ] Yes | _____ | [ ] No |

## FAMILY HISTORY

**INSTRUCTIONS: Please note any FAMILY history (parents, grandparents, siblings, and/or children – living or deceased) of the following medical conditions:**

| | | Relation | | | | Relation | |
|---|---|---|---|---|---|---|---|
| Blindness | [ ] Yes | _____ | [ ] No | Lupus | [ ] Yes | _____ | [ ] No |
| Crossed eyes | [ ] Yes | _____ | [ ] No | Cancer | [ ] Yes | _____ | [ ] No |
| Macular degeneration | [ ] Yes | _____ | [ ] No | Heart disease | [ ] Yes | _____ | [ ] No |
| Cataract | [ ] Yes | _____ | [ ] No | Kidney disease | [ ] Yes | _____ | [ ] No |
| Glaucoma | [ ] Yes | _____ | [ ] No | Thyroid disease | [ ] Yes | _____ | [ ] No |
| High blood pressure | [ ] Yes | _____ | [ ] No | Diabetes | [ ] Yes | _____ | [ ] No |
| Arthritis | [ ] Yes | _____ | [ ] No | Loss of central vision | [ ] Yes | _____ | [ ] No |
| Retinal Detachment | [ ] Yes | _____ | [ ] No | Other | [ ] Yes | _____ | [ ] No |

## SOCIAL HISTORY

**INSTRUCTIONS: Please answer the following questions related to your social history:**

| | Current | | | |
|---|---|---|---|---|
| Tobacco: | [ ] Every day | [ ] Some days | [ ] Former | [ ] Never |
| Alcohol: | [ ] Every day | [ ] Some days | [ ] Former | [ ] Never |
| Illegal drugs: | [ ] Every day | [ ] Some days | [ ] Former | [ ] Never |
| Infection/exposure: | [ ] Every day | [ ] Some days | [ ] Former | [ ] Never |

**Cataract Evaluation Appointments - Leave contact lenses out prior to your appointment as follows:**
**Soft Lenses - 7 days Gas Perm/Hard Lenses - 14 days**



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## FORMULARY BENEFITS DATA CONSENT FORM

Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of

By signing below I give permission for **Eye Group** and/or **Eye Surgery and Laser Center (ESLC)** to access my pharmacy benefits data electronically through SureScripts.

This consent will enable **Eye Group** and/or **ESLC**:

Determine the pharmacy benefits and drug copays for a patient's health plan.

Check whether a prescribed medication is covered (in formulary) under a patient's plan.

Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.

Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.

Download a historic list of all medications prescribed for a patient by any provider.

**In summary, we ask your permission to obtain your prescription plan information, and/or download the medications that you are taking.**

**Please Initial only ONE** and **Provide your Name and Date of Birth**

_____ Yes, I agree to the above
Initial

_____ No, I do not agree to the above
Initial

Patient Name _____ Patient Date of Birth _____



Patient Name: _____
DOB: _____

# Medication List

**Last Updated:** _____ **Pharmacy:** _____

**Current Medications:**

**Discharge Medications (Office Use Only)**

| Routinely Taken Medication Name (Includes OTC & Herbs) | Strength/Dose | Frequency | Resume After Surgery | |
|---|---|---|---|---|
| | | | Yes | No |
| | | | | |
| | | | | |
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**(Continue on a Separate Page if Necessary)**

| Allergies | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Patient Signature:** _____
**Date:** _____

**Physician Signature:** _____
**Date:** _____



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**Please complete the FRONT AND BACK of each page**

## AUTHORIZED RELEASE OF PERSONAL MEDICAL INFORMATION

Please list family member/others whom our staff may speak with regarding, but not limited to, your medical information such as:

- Coordination of Care
- Billing / Insurance
- Scheduling

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

**Please list any Specific Instructions or Limitations:**

_____

_____

_____

**This authorization will remain in effect unless request is received by our office in writing.**

**By signing this form, I authorize the release of my personal medical information to above persons.**

**Patient or Responsible Party Signature** _____ **Date**_____



## IMPORTANT MEDICAL INSURANCE INFORMATION

Eye Group no longer accepts assignment on Vision Plans for new patients.

We hope this information is helpful in explaining the role of Vision and Medical Insurance.We also have a dedicated billing staff that is available to assist you at any time at your request. We thank you again for choosing us to be your eye care provider.

**Patient or Responsible Party Signature** _____ **Date**_____



Please complete the FRONT AND BACK of each page

# BILLING AND INSURANCE POLICIES

**PLEASE READ AND SIGN:**

We look forward to treating your ophthalmic needs. To enable us to best treat you we would like to provide you with our billing and insurance policies as they relate to you.

I request that assignment of my healthcare insurance benefits be made to Elizabeth Wyatt Mitchell Eye Care, P.A., Kevin Kosek Eye Clinic, P.A., and/or Lee Moore, M.D., d/b/a Eye Group ("ESLC") for any services.

We may require you to have a refraction once a year. Refraction is the test to determine whether you need a prescription for eyeglasses in order to obtain your best vision or if your current glasses need to be updated. This is a necessary part of a thorough eye exam and is not a covered service by insurance. There will be a charge which will be paid at the time of the visit. An eyeglass prescription will not be issued otherwise.

Our policy requires you to present insurance cards (if applicable) at every visit. Every effort is made to verify insurance coverage before services can be rendered. Verification of insurance coverage is not a guarantee of payment by your insurance company. If we are unable to verify your coverage and benefits you may be required to pay in full up front. However, if your insurance company does reimburse for services we will refund you the amount overpaid. **Please note that if your insurance requires an authorization to see a specialist, you will need to call your primary care physician at least 72 hours prior to each appointment. Our office cannot obtain authorization for you. In the event you have a change in your insurance policy prior to the day of your scheduled procedure or visit you must notify our office immediately. Failure to do so may result in charges not being covered by your insurance providers.**

As mandated by the federal government, all insurance companies including Medicare require that you, the patient, pay your co-pay/deductible/co-insurance as part of your contract with your insurance company. Failure to do so is a violation of your contract and against the law. Because of this we cannot waive co-pays and deductibles. We require you pay your co-pay/deductible/co-insurance at the time of each appointment.

I agree to pay 1½% of the unpaid past due balances for collection costs, or alternatively the maximum lawful fee, at such time account is placed with a collection agency. I further understand that in the event the account is referred to an attorney for collection, I agree to be liable for such additional reasonable court costs and attorney's fees as may be determined by a court. I give my consent to receive communication from servicers and collectors of my accounts with contact information provided by Eye Group.

I understand that there may be a charge for providing me or my representative(s) with copies of my medical records in accordance with the guidelines provided by the MS State Board of Medical Licensure.

**Patient or Responsible Party Signature** _____ **Date**_____



**PLEASE READ AND SIGN:**

I understand that there may be a charge for the completion of forms such as, but not limited to, FMLA, appeals, physicals, workman's compensation, etc. Forms shall be completed within a reasonable time. Forms shall NOT be completed the same day of the request.

If I have a medical problem and seen as a same day work in patient, I may be charged CPT Code 99058. This charge may not be paid by my insurance company.

The waiting room doors will be locked at 4:30 p.m. "Late" is defined as 15 minutes after the scheduled appointment and may result in having to reschedule the appointment. If you need to cancel or reschedule your appointment, please do so 24 hours prior to the appointment. Failure to give proper notice or cancellation may result in assessment of a no show fee. Patients that accrue three no shows may be discharged from the practice.

Requests for copies of medical records and prescriptions will be processed within 3 to 5 days of the request. Requests may be made by either calling, emailing, or through the website/ portal.

I understand the Eye Group and/or The Eye Surgery and Laser Center, LLC ("ESLC") may use phone texts to contact me for appointments, upcoming events, or educational purposes. If I receive a text, I will have the ability to opt out of future texts at that time.

In the event of a security breach or other system wide correspondence that requires my notification, I authorize you to contact me by the email address I have provided to you. I understand that: If I do not have access to email, that I will be informed by phone or mail; That I am responsible for giving you any updates of my email address; and that the Eye Group will not be held responsible if they are unable to contact me if I have not done so.

**Patient or Responsible Party Signature** _____ **Date**_____