Account #_____

PATIENT DEMOGRAPHIC SHEET

(MR/MRS/MS/DR) FIRST_____ MI_____ LAST_____

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY #: _____

MAILING ADDRESS: _____

ZIP CODE: _____ CITY: _____ STATE: _____

HOME PHONE #:(_____) _____-_____ CELL PHONE #:(_____) _____-_____ PRIMARY: HOME/CELL

OKAY TO LEAVE VOICEMAIL? YES____ NO____ OKAY TO TEXT? YES____ NO___

EMAIL: _____ GENDER: (CIRCLE ONE) FEMALE MALE

RACE: _____ PRIMARY LANGUAGE: _____ LANGUAGE BARRIER? YES NO

MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED DIVORCED WIDOWED OTHER

EMERGENCY CONTACT NAME: _____

RELATIONSHIP TO PATIENT: _____EMERGENCY CONTACT #:(_____) _____-_____

PRIMARY CARE PHYSICIAN: _____PHONE#:(_____) _____-_____

REFERRING DOCTOR: _____ PHONE#:(_____) _____-_____

PRIMARY INSURANCE: _____ Policy #: _____ Group #: _____
Name of Insured: _____ Insured DOB: _____ Insured SSN: _____

SECONDARY INSURANCE: _____ Policy #: _____ Group #: _____
Name of Insured: _____ Insured DOB: _____ Insured SSN: _____

Treatment of Minors

Many times, parents find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

I, _____ hereby grant North Georgia Eye Associates to treat my child when they arrive unaccompanied.
(AS LISTED ON HIPPA FORM)

Mothers Name: _____ Cell #: _____ SS#: _____
DOB: _____ Work #: _____ Address: _____
Mother Employer & Address: _____

Fathers Name: _____ Cell #: _____ SS#: _____
DOB: _____ Work #: _____ Address: _____
Fathers Employer & Address: _____

Account #_____

NORTH GEORGIA EYE ASSOCIATES

FINANCIAL POLICY

Thank you for choosing North Georgia Eye Associates as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

Co-pays

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

Self-pay Accounts

Self-pay accounts are patients with no healthcare coverage, patients covered by insurance plans in which the office does not participate, and/or patients that do not have their insurance card or insurance information the day of their visit. It is always the patient's responsibility to know if our office is participating with their plan. Self-pay patients will be required to bring payment in full at the initial appointment.

Health Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract, however we will bill your primary insurance as a courtesy to you. You are responsible to pay the usual and customary fees deemed by NGEA for services rendered that are not covered by your insurance like refractions, copays, deductibles and coinsurance. Using medical insurance benefits for a medical eye exam is necessary for the diagnosis/treatment of disease and conditions of the eye performed by a physician or surgeon. I understand that if there is no medical problem, a medical diagnosis will not be made by the physician, Therefore, my medical insurance will not be filed, and I will be financially responsible for services rendered that day.

Vision Insurance Claims

During my exam I will be examined for any needed correction (glasses or contact lenses) or any potential indicators of eye disease. If the provider finds anything abnormal during my vision exam, further testing may be needed at another visit. In that case my medical insurance would be billed. I understand that Routine Vision exams do not qualify for prescribing medications and that contact lens fittings are specific to each individual's needs, and I may be responsible for certain costs not covered under my vision plan.

Workers Compensation

It is the patient's responsibility to provide NGEA with employer authorization/contact information regarding a workers' compensation claim. If the claim is denied by the workers' compensation insurance carrier, it then becomes the patient's responsibility.

NORTH GEORGIA EYE ASSOCIATES, LLC. RESERVES THE RIGHT TO CHANGE AND/OR MODIFY THE INFORMATION ON THIS SITE AT ANY TIME.

Patient Signature:_____Date:_____

NORTH GEORGIA EYE
ASSOCIATES

HIPPA CONSENT

Patient consent for North Georgia Eye Associates and Gainesville Eye Center to use or disclose health care information for treatment, payment and health care. North Georgia Eye Associates and Gainesville Eye Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, race or gender.

I understand that my health information is private and confidential. I understand that North Georgia Eye Associates and Gainesville Eye Center works very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that signing this document means that North Georgia Eye Associates and Gainesville Eye Center may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. You may refuse to sign this consent form.

Under the terms of this consent, I can ask North Georgia Eye Associates and Gainesville Eye Center to restrict how my personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that North Georgia Eye Associates and Gainesville Eye Center do not have to agree to my request. If North Georgia Eye Associates and Gainesville Eye Center do not agree to my request, I understand that North Georgia Eye Associates and Gainesville Eye Center would follow the agreed limits.

I understand that I have the right to cancel this consent in writing at any time. If I do cancel the consent, I understand that North Georgia Eye Associates and Gainesville Eye Center may have already used or disclosed information about me and canceling this consent would not affect the information already used or disclosed. I understand it is my responsibility to contact the North Georgia Eye Associates Privacy Officer in writing to terminate the authorization.

I give consent to North Georgia Eye Associates and Gainesville Eye Center to discuss health care information with:

Name	Phone Number	Relationship to Patient

This authorization expires:

- ☐ No expiration date.
- ☐ Date Specified_____/_____/_____-unless revoked or terminated in **writing** by you or your personal patient representative.
- ☐ I decline permission to discuss medical information.

_____ _____ _____

Signature of Patient (Guardian if under 18) Date Relationship to Patient

North Georgia Eye Associates and Gainesville Eye Center, LLC

PATIENT NAME:			DATE OF BIRTH: _____/_____/_____	AGE:	SEX: M/F
Email Address:	WEIGHT:	HEIGHT:	PRIMARY PHONE #: (_____)_____-_____		

DO YOU HAVE A LIVING WILL? YES NO DO YOU HAVE A POWER OF ATTORNEY? YES NO FALL RISK? YES NO

SURGERIES (LIST ALL OPERATIONS): _____

_____

MEDICAL HISTORY:	**CIRCLE**		**IF YOU ANSWER YES, PLEASE EXPLAIN**
1. High/Low Blood Pressure (# of years)_____	YES	NO	_____
2. High Cholesterol/Triglycerides	YES	NO	_____
3. Heart Attack, Chest Pain or Angina	YES	NO	_____
4. Heart Problems (Heart murmur, pacemaker, bypass surgery, heart failure, mitral valve prolapses)	YES	NO	_____
5. Stomach or Intestinal Problems (acid reflux, hiatal hernia, ulcers)	YES	NO	_____
6. Lung Problems (asthma, emphysema, persistent cough, chronic bronchitis, COPD)	YES	NO	_____
7. Sleep Apnea Do you use CPAP?	YES	NO	_____
8. Diabetes (insulin/oral meds) # of years_____ Type 1 or 2, Last Fasting BS_____ Last A1C_____/Date_____	YES	NO	_____
9. Do you have an infectious disease (hepatitis, HIV/AIDS, MRSA, TB)	YES	NO	_____
10. Kidney Problems	YES	NO	_____
11. Thyroid Problems	YES	NO	_____
12. Blood Clots, Clotting Problems, Bleeding	YES	NO	_____
13. Stroke (numbness/weakness)	YES	NO	_____
14. Epilepsy or Convulsive Seizures	YES	NO	_____
15. Cancer	YES	NO	_____
16. Lupus	YES	NO	_____
17. Arthritis	YES	NO	_____
18. Rheumatoid Arthritis	YES	NO	_____
19. Psychological/Emotional Problems (depression, anxiety)	YES	NO	_____
20. Problems with Motion Sickness	YES	NO	_____
21. Problems with Anesthesia (you or blood relative)	YES	NO	_____
22. Females Only: Do you still have cycles?	YES	NO	_____
23. Males Only: Prostate Disease-enlarged/cancer	YES	NO	_____
24. Flu Vaccine	YES	NO	When? _____
25. Pneumonia Vaccine	YES	NO	When? _____
26. Shingles Vaccine	YES	NO	When? _____
27. COVID Vaccine	YES	NO	When? _____
DO YOU:			
28. Wear dentures or partials/crowns	YES	NO	
29. Drink alcohol or use drugs (how much) _____	YES	NO	
30. Smoke (how much) _____Quit (when)_____	YES	NO	
31. Communication barrier due to medical condition	YES	NO	

_____

Patient Signature Date

_____

Doctor Signature Date

OFFICE USE ONLY

DATE OF SURGERY:
PROCEDURE:
PT INFORMED: NPO, DRIVER NEEDED, PRE-OP
GTTS AS INSTRUCTED BY SURGEON
ARRIVAL TIME:
NURSE:
ANESTHESIA:

PATIENT STICKER

North Georgia Eye Associates and Gainesville Eye Center, LLC

PATIENT NAME:	BIRTHDATE: ____/_____/_____	AGE:	SEX: M F

LIST ANY PROBLEMS YOU ARE HAVING WITH YOUR EYES OR YOUR GLASSES: _____

_____

PAST EYE SURGERIES/DATES: _____

_____

DO **YOU** HAVE A HISTORY OF ANY OF THE FOLLOWING:	**CIRCLE**	**IF YOU ANSWER YES, PLEASE EXPLAIN**
1. Do you have cataracts?	YES NO	_____
2. Have you had cataract surgery? (If so when, where and what surgeon?)	YES NO	_____ _____
3. Glaucoma? (If YES, type of treatment/drops)	YES NO	_____
4. Trauma/Injury (when/what type of injury)	YES NO	_____
5. Ocular Herpes	YES NO	_____
6. Severe Dry Eyes	YES NO	_____
7. Retinal Detachment	YES NO	_____
8. Macular Degeneration	YES NO	_____
9. Abnormal vision during youth	YES NO	_____

FAMILY HISTORY:		**RELATIONSHIP TO YOU**
1. Eye diseases/blindness (Cataracts, macular degeneration, retinal detachment, glaucoma)	YES NO Explain: Circle:	_____ _____ Mom/Dad/Sister/Brother/Grandparent
2. Diabetes, Heart disease, hypertension	YES NO Circle:	_____ Mom/Dad/Sister/Brother/Grandparent
3. Other _____ _____		

HAVE YOU EVER USED:		**WHEN/HOW LONG**
Restasis	YES NO	_____
Xiidra	YES NO	_____
Refresh	YES NO	_____
Systane	YES NO	_____
Other: _____		

_____
Patient Signature Date

_____
Doctor Signature Date

North Georgia Eye Associates and Gainesville Eye Center, LLC

PATIENT MEDICATION LIST

Patient Name: _____ Date of Birth: _____/_____/_____

Primary Care Physician: _____ Phone#:(_____) _____-_____

Referring Physician: _____ Phone#:(_____) _____-_____

Pharmacy: _____ Phone#:(_____) _____-_____

Allergies: (list all allergies, including food, latex and medications) Please include reactions to items you listed as allergies, i.e., rash, fever, nausea/vomiting, etc.) or No Allergies._____

_____

_____

Please list all medications you are currently taking. (Including vitamins, herbal supplements, antacids, or OTC (over the counter) medications or, see attached list.

NAME OF MEDICATION/VITAMINS/HERBAL SUPPLEMENTS/ETC.	DOSE	FREQUENCY TAKEN (Once/Twice a day, etc.)

OFFICE USE ONLY:

Date: _____

Reviewed By: _____

***This is an updated medication list. ***

PATIENT LABEL HERE

NORTH GEORGIA EYE ASSOCIATES

GLASSES PRESCRIPTION TEST

Refraction Consent

- Most insurance companies **do not cover** the test for a glasses prescription (a refraction.)

- As a convenience to our patients, we can offer this service at the time of the **medical eye exam** that you are having today.

- The cost for this test is $40.00, which is less costly than most facilities. **This is separate from your co-pay or deductible due at the end of your visit.**

Would you like to be tested for a prescription for glasses today?

YES_____ NO_____

_____ _____

Patient Signature Patient Name / DOB (please print)

_____ _____

Staff Member Date