Welcome to Our Office

Name ____________________________________ Today's Date ______________

Address _________________________ City ________ State ______ Zip _______

Home Phone______________________ Cell Phone_________________________

Date of Birth _____________________ Social Security # ____________________

Race/Ethnicity ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐ Other

Employer ___________________________ Occupation _____________________

Email ____

Insurance

(Please list both medical and vision insurance for the office to keep on file if needed.)

Medical Insurance Company Name ___________________________________

Medical Insurance ID Number ______________________________________

Medical Insurance Group ID ____

Vision Insurance Company Name ____________________________________

Vision Insurance Company ID_______________________________________

Insured Name_______________________ Insured DOB__________________

Medical History
(Please list year of diagnosis and description if needed)

Constitution:
- Developmental Disabilities________________
- Cancer__________________________________
- Fatigue Syndrome_______________________
- Other___________________________________

ENT:
- Hearing Loss____________________________
- Sinusitis________________________________
- Dry Mouth______________________________
- Laryngitis_______________________________
- Other___________________________________

Neurological:
- Multiple Sclerosis________________________
- Epilepsy_________________________________
- Cerebral Palsy___________________________
- Tumor__________________________________
- Migraine________________________________
- Autism Spectrum Disorder________________
- Other___________________________________

Psychological:
- Depression______________________________
- Attention Deficit_________________________
- Anxiety Disorder_________________________
- Bipolar Disorder_________________________
- Other___________________________________

Cardiovascular:
- Hypertension____________________________
- Stroke/CVA______________________________
- Heart Disease____________________________
- Vascular Disease_________________________
- Congestive Heart Failure__________________
- Other___________________________________

Respiratory:
- Cigarette Smoker_________________________
- Asthma_________________________________
- Bronchitis_______________________________
- Emphysema______________________________
- Chronic Obstruction______________________
- Sleep Apnea_____________________________
- Other___________________________________

Gastrointestinal:
- Crohn's_________________________________
- Colitis__________________________________
- Ulcer___________________________________
- Acid Reflux______________________________
- Celiac Disease____________________________
- Other___________________________________

Genitourinary:
- Kidney Disease___________________________
- Prostate Disease/Cancer__________________
- STD_____________________________________
- Benign Prostate Hypertrophy______________
- Pregnant/Nursing_________________________
- Other___________________________________

Musculoskeletal:
- Osetoarthritis____________________________
- Fibromyalgia_____________________________
- Muscular Dystrophy______________________
- Ankylosing Spondylitis____________________
- Gout____________________________________
- Other___________________________________

Integumentary:
- Eczema__________________________________
- Rosacea_________________________________
- Psoriasis________________________________
- Herpes Simplex/Cold Sores________________
- Herpes Zoster/Shingles___________________
- Other___________________________________

Endocrine:
- Diabetes (Type 1 or Type 2)________________
- Thyroid Dysfunction______________________
- Hormonal Dysfunction_____________________
- Other___________________________________

Hematological:
- Anemia__________________________________
- Severe Blood Loss________________________
- High Cholesterol__________________________
- Other___________________________________

Allergic/Immune:
- Drug Allergies____________________________
- Environmental Allergies___________________
- Rheumatoid Arthritis_____________________
- Lupus___________________________________
- Sjogren's Syndrome______________________
- Other___________________________________

Allergies: (List ANY medication, food, environmental, latex, dye allergies)

Current Medication: (List all medications taken daily including vitamins or attach list to copy)

Past Eye History:

Eye Surgery: ________________________
Eye Injury: _________________________
Eye Disease: ________________________

Social History:

Do you drive?
Do you smoke?
How much do you smoke?
Do you use illegal drugs?
Do you drink alcohol?

Height_____________ Weight _____________

Family Medical History: (Please list close relatives with conditions)

Glaucoma:
Diabetes:
Macular Degeneration:

Name of Primary Care Physician: (Please list office name)

Pharmacy & Location:

Eye Care Associates
For A Lifetime of Healthy Vision
662-205-4654

Dr. Katie Richardson
Dr. Josh Hatfield

Disclosure of Personal Health Information:

Eye Care Associates will not discuss your personal health information with anyone except those allowed under federal and state law without your authorization. This form is good for a lifetime or until a change is requested and a new form filled out.

Please list the names and relationships of those you authorize us to disclose your personal health information.

Contact Names:	Relationship:	Phone Number:
___________________________	______________________	_________________________
___________________________	______________________	_________________________

Patient/Guardian Signature: ______________________________________ Date: ____________________________

Financial Agreement:

Payment is due in full when services are received.

I fully understand that I am ultimately responsible for all charges associated with my account. This also includes deductibles, co-payments, and any charges that insurance may not cover if any insurance is filed on my behalf. If I fail to pay any amount due, I will also be responsible for all collection fees, court costs, attorney fees, and any other charges incurred in the collection of any balance due.

Signature: ____ Date: ____________________________________

HIPAA INFO RECIEVED INITIALS: ______________

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Medical Testing Authorization

At Eye Care Associates our goal is to take care of our patients' vision and eye health to the best of our ability. To do this, we have incorporated Digital Retinal Imaging into our protocol for a comprehensive eye examination. This testing does not replace the need for dilation; however, it allows us instant views of your retina for evaluation today and comparison in the future. The charge for this procedure is $30 and is recommended by our doctors to be done on an annual basis. If you wish to have Digital Retinal Imaging today, simply return this form completed. Please select an option below (x) and return this form to the front desk.

______ I wish to have Digital Retinal Imaging today.

______ I understand that my doctor encourages Digital Retinal Imaging to best care for my eyes, however, I choose to decline this procedure today.

Patient Signature: ____ Date: _____________________________