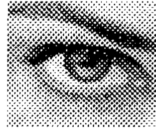
PATIENT INFORMATION FORM



Advanced Vision, P.C.
2799 Lawrenceville Highway Suite 104
Decatur, Georgia 30033
(678) 534-0200

Name: ______________________________ ☐ Male ☐ Female
Last First Middle

Address: ______________________________ Apt: __________

City: ______________________ State: ________ Zip: __________

Social Security Number: __________________ Home Phone: __________________

Birthdate: __________________ Cell Phone: __________________

Email: __________________ Work Phone: __________________

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced

Referred By: ______________________________

Employer: ______________________________

Race: ______________________________

Nearest Relative/Friend: __________________ Phone Number: __________________

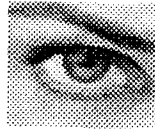
I authorize my doctor to release to Medicare or any other insurance carriers and medical or other information needed for all services I receive. I request all insurance paymentsbe made directly to my doctor. I understand that if my insurance does not pay within 60 days or decides that a service is "not covered" that a bill will be sent directly to me and I am responsible for payment. I further understand that I am responsible for any deductible, co-insurance and refraction fees at the time of service.

I also understand that, if at any time, I change my insurance carrier, I am responsible for notifying your office of such change. If I fail to notify the office of this change and I decide to be seen, I understand that my services will be considered out of network and I will be solely responsible for the charges incurred.

If I choose to be on a Managed Care plan that requires a referral, I understand it is my responsibility to obtain said referral prior to be seen.

Signature: ______________________________ Date: __________________

MEDICAL HISTORY FORM



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(678) 534-0200

Name: ______________________ Date: ______________

Current Occupation (If retired, please list previous occupations):

____

What are your hobbies / interests?

____

Reason for today's visit:

____

Please list the name and phone number of your family doctor.

____

Have you had any eye surgery? ☐ Yes ☐ No
If yes, please list what type, the date of the surgery and the name of the surgeon.

____

Do you use eye drops? ☐ Yes ☐ No
If yes, please list them.

____

Do you have an intraocular lens or implant? ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No
If yes, please list them.

____

Are you currently taking any medications? ☐ Yes ☐ No
If yes, please list them.

____

____

____

____

Please list any surgeries that you have had other than eye surgery.

____

____

Do you have a family history of:

Diabetes	☐ Yes	☐ No	Other:
Stroke or Heart Attack	☐ Yes	☐ No	______________
Macular Degeneration	☐ Yes	☐ No	______________
Retinal Detachment	☐ Yes	☐ No	______________
Glaucoma	☐ Yes	☐ No	______________
Blindness	☐ Yes	☐ No	______________

Have you ever had (or do you have now) and of the following:

If yes, please list the dates (such as diabetes since 1979 or stroke in May, 1990) and give other important information.

Condition	Yes	No	Date
High Cholesterol	☐ Yes	☐ No	Date:
Diabetes	☐ Yes	☐ No	Date:
Thyroid Disease	☐ Yes	☐ No	Date:
High Blood Pressure	☐ Yes	☐ No	Date:
Heart Disease	☐ Yes	☐ No	Date:
Heart Attack	☐ Yes	☐ No	Date:
Bypass Surgery	☐ Yes	☐ No	Date:
Congestive Failure	☐ Yes	☐ No	Date:
Irregular Beat	☐ Yes	☐ No	Date:
Chest Pain	☐ Yes	☐ No	Date:
Lung Disease	☐ Yes	☐ No	Date:
Asthma	☐ Yes	☐ No	Date:
Emphysema	☐ Yes	☐ No	Date:
Tuberculosis	☐ Yes	☐ No	Date:
Shortness of Breath	☐ Yes	☐ No	Date:
Stomach Problems	☐ Yes	☐ No	Date:
Ulcers	☐ Yes	☐ No	Date:
Stomach Pain	☐ Yes	☐ No	Date:
Liver Disease	☐ Yes	☐ No	Date:
Hepatitis	☐ Yes	☐ No	Date:
Yellow Jaundice	☐ Yes	☐ No	Date:
Bowel Changes or Problems	☐ Yes	☐ No	Date:
Muscle Weakness	☐ Yes	☐ No	Date:
Neurological Problems	☐ Yes	☐ No	Date:
Stroke	☐ Yes	☐ No	Date:
Paralysis	☐ Yes	☐ No	Date:
Numbness or Tingling	☐ Yes	☐ No	Date:
Headache	☐ Yes	☐ No	Date:
Kidney Problems	☐ Yes	☐ No	Date:
Stones	☐ Yes	☐ No	Date:
Failure	☐ Yes	☐ No	Date:
Trouble Urinating	☐ Yes	☐ No	Date:
Skin Problems	☐ Yes	☐ No	Date:
Rash	☐ Yes	☐ No	Date:
Changes in Skin Color	☐ Yes	☐ No	Date:
Anemia	☐ Yes	☐ No	Date:
Bleeding Trouble	☐ Yes	☐ No	Date:
Blood Transfusion	☐ Yes	☐ No	Date:
Trouble Hearing	☐ Yes	☐ No	Date:
Dizziness/Vertigo	☐ Yes	☐ No	Date:
Ringing in Ears	☐ Yes	☐ No	Date:
Cancer	☐ Yes	☐ No	Date:
Infectious Disease	☐ Yes	☐ No	Date:
Organ Transplant	☐ Yes	☐ No	Date:
Mental Illness	☐ Yes	☐ No	Date:

Please list any disorder or medical condition which you have had in the past but has not been noted above:

____

Have you ever smoked? ☐ Yes ☐ No ☐ Quit? When? ________________

If yes, how much and for how long? ________________________

Do you drink alcohol? ☐ Yes ☐ No

If yes, how much alcohol do you drink daily? ________________________

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the HIPPA Compliance Privacy Laws of the Federal Government, it is mandatory that we ask you to review and answer the following questions listed below.

PATIENT: ____ DOB: __________________

May we contact/leave messages/detailed medical information on voicemail at any of these phone numbers?

Home Phone: ___________________ Yes ☐ No ☐

Cell Phone: _____________________ Yes ☐ No ☐

Work Phone: ____________________ Ext: _______ Yes ☐ No ☐

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general, surgical, and billing)?

Yes ☐ No ☐ If yes, please provide:

Name: ____ Relationship: ________________

Phone Number: _______________________ Alternate Number: _________________________

Name: ____ Relationship: ________________

Phone Number: _______________________ Alternate Number: _________________________

Name: ____ Relationship: ________________

Phone Number: _______________________ Alternate Number: _________________________

I hereby authorize Advanced Vision, PC to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. This authorization remains in effect until revoked.

I have reviewed Advanced Vision's Notice of HIPPA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _______________________________________ Date: __________________

Witnessed By: ____ Date: __________________