MCMINN EYE CARE CLINIC
PATIENT INFORMATION

PERSONAL INFORMATION:

Name: _____ Social Security #: _____

Sex: M F Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ □ Minor □ Single □ Married □ Widowed □ Divorced

Employed By: _____ Occupation: _____

In case of emergency, who should be notified? _____ Phone: _____

COMPLETE IF UNDER 18 YEARS OR A STUDENT:

Name of Father: _____ Date of Birth: _____ Employer: _____

Address: _____ Social Security #: _____ Phone: _____

Name of Mother: _____ Date of Birth: _____ Employer: _____

Address: _____ Social Security #: _____ Phone: _____

INSURANCE INFORMATION: ****** PLEASE SHOW INSURANCE CARDS******

Primary **Medical** Insurance: _____ ID #: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____ Subscriber's SSN: _____ Relationship to Patient: _____

Secondary **Medical** Insurance: _____ ID #: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____ Subscriber's SSN: _____ Relationship to Patient: _____

Is Patient Covered by **Vision** Insurance? □ YES □ NO

Vision Insurance Company: _____ ID #: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____ Subscriber's SSN: _____ Relationship to Patient: _____

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. I herby authorize McMinn Eye Care Clinic to apply benefits for covered services rendered. I certify that the information I have reported to McMinn Eye Care Clinic with regard to my insurance is correct. I understand that I am ultimately responsible for all charges accumulated. I hereby authorize the doctor to release all information to secure the payment of benefits, and authorize the use of this signature on all insurance submissions.
2. I give permission for treatment of myself/ my dependent to my assigned provider.
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to Justin S. McMinn, O.D. and/or Haley N. Wilson, O.D. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or benefits payable for related services.
4. I hereby authorize Justin S. McMinn O.D. and/or Haley N. Wilson, O.D. (McMinn Eye Care Clinic) to apply for benefits on my behalf for covered services rendered by this provider. I also assign my benefits and request that all payments be made directly to Justin S. McMinn, O.D. and/or Haley N. Wilson, O.D.(McMinn Eye Care Clinic).
5. Upon Completion and processing of vision plan claim, I agree to assume responsibility of payment in full for any remaining balance that is not covered by my vision plan.

_____ _____

Signature (Patient or Parent if minor) Date

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date _____

Date of **Birth** _____ Date of **last eye exam** _____

List any **medications** you currently take (Rx and over-the-counter): _____

_____

Do you have **allergies** to any medications? **YES NO**
If YES, list the medications: _____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

_____

List any **surgeries** you have had (cataract, appendectomy): _____

Do you *currently* have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply) ? **YES** **NO** **UNKNOWN**

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES** **NO**
Have you ever had a blood transfusion?..... **YES** **NO**
Do you drink alcohol?..... **YES** **NO** If YES, how much? _____
Do you smoke?..... **YES** **NO** If YES, how much? _____ How many years? _____

Please do not sign only

Physician's Signature _____ *Date* _____