

**EYE CARE CENTER ASSOCIATES, P.A. PATIENT INFORMATION**

**PLEASE COMPLETE FRONT AND BACK, SIGN & RETURN TO RECEPTIONIST**

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CHART NUMBER

DATE \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ Male Female (Circle One)

last first middle

SS# \_\_\_\_\_ BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_

ADDRESS \_\_\_\_\_  
Mailing address city state zip code

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

EMPLOYED BY: \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_  
Street address city state zip code

MARITAL STATUS MARRIED SINGLE DIVORCED SEPARATED WIDOW/ER MINOR (Circle One)

SPOUSE OR PARENT \_\_\_\_\_ Male Female (Circle One)

last first middle

ADDRESS: \_\_\_\_\_  
Mailing address city state zip code

SOCIAL SECURITY # \_\_\_\_\_ PHONE# \_\_\_\_\_ BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYED BY: \_\_\_\_\_ PHONE # \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street address city state zip code

EMERGENCY CONTACT: LOCAL FRIEND OR RELATIVE \_\_\_\_\_  
(Outside of home) Name phone

WHO REFERRED YOU TO THIS OFFICE? \_\_\_\_\_

**PATIENT INFORMATION:**

WHO IS RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT?

PATIENT PARENT, IF PATIENT UNDER 18 YEARS OF AGE EMPLOYER IF WORK-RELATED INJURY  
(Parent bringing child is responsible)

**IF SOMEONE ELSE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, PLEASE COMPLETE THIS SECTION:**

\_\_\_\_\_ Male Female SS# \_\_\_\_\_  
LAST FIRST MIDDLE (Circle One)

PHONE: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_ BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS: \_\_\_\_\_  
Mailing address city state zip code

EMPLOYED BY: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street address city state zip code

SIGNATURE OF RESPONSIBLE PARTY: \_\_\_\_\_

IF INJURY, INDICATE DATE OF INJURY: \_\_\_\_/\_\_\_\_/\_\_\_\_ AND LOCATION \_\_\_\_\_

**PLEASE READ AND SIGN BACK OF FORM FOR INSURANCE/PAYMENT INFORMATION**

# INSURANCE

**PLEASE PRESENT YOUR INSURANCE CARDS TO THE RECEPTIONIST BEFORE BEING SEEN.**

(IF AT ANY TIME YOUR INSURANCE COVERAGE CHANGES, OR THEIR ADDRESS CHANGES PLEASE CONTACT OUR OFFICE WITH THAT INFORMATION. FAILURE TO DO SO MAY RESULT IN AN UNBILLABLE CLAIM TO INSURANCE.)

PLEASE BE AWARE THAT CHARGES ARE MADE TO THE PATIENT. FILING OF INSURANCE IS DONE AS A COURTESY. ALL BALANCES NOT PAID BY INSURANCE ARE DUE FROM THE PATIENT OR RESPONSIBLE PARTY NO LATE THAN **NINETY (90) DAYS** BEYOND THE DATE SERVICES ARE RENDERED. PATIENTS ARE RESPONSIBLE FOR THEIR PORTION OF COPAYS, DEDUCTIBLES, COINSURANCES, AND NON-COVERED SERVICES ON THE DATE SERVICES ARE RENDERED. FAILURE TO PAY ANY PORTION DEEMED AS INSURED RESPONSIBILITY BREAKS THE AGREEMENT YOU HAVE MADE WITH YOUR INSURANCE COMPANY AND MAY RESULT IN YOUR INSURANCE TERMINATING COVERAGE.

EYE CARE CENTER WILL FILE **MEDICARE, TRI-CARE,** AND **SOME, BUT NOT ALL** COMMERCIAL INSURANCE. PLEASE CHECK YOUR HANDBOOK OR CALL YOUR INSURANCE COMPANY IF THERE ARE QUESTIONS REGARDING BENEFITS OR PHYSICIAN PARTICIPATION IN YOUR INSURANCE NETWORK.

**REFERRALS:** IF YOUR POLICY REQUIRES A REFERRAL, PLEASE PRESENT IT TO THE RECEPTIONIST BEFORE BEING SEEN. IF A REFERRAL IS NOT OBTAINED PRIOR TO YOUR APPOINTMENT, PAYMENT IS DUE ON DATE SERVICE IS RENDERED AND INSURANCE CANNOT BE FILED. YOU ARE ALWAYS WELCOME TO RESCHEDULE YOUR APPOINTMENT WHEN REFERRAL IS OBTAINED.

## TENN CARE

EYE CARE CENTER CURRENTLY FILES BlueCare and TN Care select.

## AGREEMENT FOR NON-COVERED SERVICES:

CERTAIN SERVICES ARE NOT COVERED BY MEDICARE. THESE INCLUDE:

REFRACTION            \$25.00    SIGNED: \_\_\_\_\_

I, the undersigned, assign directly to EYE CARE CENTER ASSOCIATES, P.A. all vision, surgical, and/or medical benefits to be paid directly to the EYE CARE CENTER ASSOCIATES, P.A. on my behalf. I request that payment of any authorized medigap benefit be paid directly to EYE CARE CENTER ASSOCIATES, P.A. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize EYE CARE CENTER ASSOCIATES, P.A. to release all medical information necessary to secure the payment of benefits. I further authorize any holder of medical information about me to release to EYE CARE CENTER ASSOCIATES, P.A. any information needed to determine these benefits.

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_                      SIGNED: \_\_\_\_\_

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_                      WITNESSED: \_\_\_\_\_

I HAVE READ AND AGREE TO ALL THE ABOVE-MENTIONED TERMS

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Eye Care Center Associates  
1100 North Jackson Street  
Tullahoma, TN 37388

I, \_\_\_\_\_, give my authorization to my physician/physicians staff to discuss any medical issues concerning me to:

\_\_\_ Spouse \_\_\_ Son/Daughter/Children \_\_\_ Caregiver \_\_\_ Other \_\_\_\_\_

Please check all that apply:

\_\_\_ I give my physician/physician's staff permission to leave a message on my home answering machine or to any person answering my home phone.

\_\_\_ I give my permission to my physician/physician's staff to contact me at my place of employment. If I am unable to be reached there, I give permission to my physician/Physician's staff to leave a message for me to return their call.

\_\_\_ I give my permission to my physician/physician's staff to fax or discuss any information regarding me to another physician/physician's office that maybe covering for my physician/physician's staff, or a physician I may be referred to by my physician/physician's staff.

If there is any medical information I do not want to be discussed or a message left at my home or at my place of employment, I will notify my physician/physician's staff of this in writing. If there is any change in information pertaining to this consent, I will also notify my physician/physician's staff of this in writing.

For your privacy, anyone you have given us permission to speak with we will ask them to verify your date of birth.

\_\_\_\_\_  
Signature and Date

\_\_\_\_\_  
Witness (Office Staff Member)

Office Use Only:

\_\_\_\_\_  
Date of Birth

NAME \_\_\_\_\_ OCCUPATION \_\_\_\_\_ DATE \_\_\_\_\_

Work: Are you in contact with any solvents, liquids, dyes, etc. YES NO

Smoke Yes No How many packs per day \_\_\_\_\_ How many years \_\_\_\_\_  
Alcohol Yes No How much per day \_\_\_\_\_  
Caffeine Yes No How much per day \_\_\_\_\_

**(1) Personal Medical History**

Dizziness	Yes	No	Seasonal allergies	Yes	No
— Glaucoma / eye problems	Yes	No	Other allergies	Yes	No
Ear /nose /throat /mouth	Yes	No	HIV /hepatitis /TB	Yes	No
HBP / heart problems	Yes	No	Skin problems	Yes	No
Blood / plasma transfusion	Yes	No	Neurological	Yes	No
Asthma / emphysema	Yes	No	Endocrine problems	Yes	No
Gallbladder disease	Yes	No	Gastro-intestinal	Yes	No
Arthritis / rheumatism	Yes	No	Cancer	Yes	No
Diabetes	Yes	No			

**(2) Family History**

Glaucoma	Yes	No
Cancer	Yes	No
Diabetes	Yes	No
HBP / heart problems	Yes	No
Stroke	Yes	No

**(3) Family Doctor**

**(4) Medicines currently taking**

**(5) Eye drops currently using**

**(6) Allergies to medications**

**(7) Surgical History**