



601 Providence Park Drive
 Mobile, AL 36695
 Tel 251-650-2020
 Fax 251-650-1010

Please make any necessary changes (and complete) to these pages and sign where indicated

Patient Name	_____	Today's date	_____		
Date of Birth	_____	Height	_____	Weight	_____

Whom may we thank for referring you?

Name of MD	_____				
Street Address	_____	City	_____	State	_____
Phone Number	_____				

In addition, to the referring doctor listed above, please list any other doctors that you have seen for this condition, as well as your **internist** or **general physician** so that we may keep them informed our findings.

Name of MD & Specialty	_____				
Street Address	_____	City	_____	State	_____
Phone Number	_____				

Name of MD & Specialty	_____				
Street Address	_____	City	_____	State	_____
Phone Number	_____				

Please answer the following questions about your medical history:

Have you ever had any eye disease?

Cataract Glaucoma Macular degeneration Dry eye Blepharitis Strabismus other _____

Have you had any eye surgery?

Cataract Glaucoma Laser Cosmetic Retina Eye Muscle Refractive other _____

Do any medical or eye diseases run in your family?

Diabetes Hypertension Heart disease Heart attack other _____

Have you ever been treated for any medical conditions?

Diabetes Hypertension Heart disease Heart attack Lung disease Thyroid Arthritis other _____

Have you ever had any surgery not listed above? no; yes Please explain _____

Have you ever been hospitalized no; yes Please explain and provide date and reason? _____

Have you ever been treated for fibromyalgia syndrome (FMS) chronic fatigue syndrome (CFS).

How much do you smoke? _____ (packs/day) **How much alcohol do you drink per week?** _____

How many hours/week do you work? _____

Does your employment contribute to any stress in your life?



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Review of Systems (check box if you have any of the following and please explain:

- Skin:** rashes excessive dryness other _____ none
- Ear/nose/throat problems** hearing loss, sinus problems sore throat other _____ none
- Heart** chest pain irregular heart beat other _____ none
- Endocrine** Diabetes Thyroid other _____ none
- Respiratory problems** shortness of breath wheezing, coughing other _____ none
- Chronic fever** unexpected weight loss/gain, fatigue other _____ none
- Gastrointestinal problems** heartburn abdominal pain diarrhea vomiting other _____ none
- Urinary problems** pain or discomfort blood in urine none other _____ none
- Musculoskeletal problems** muscle aches joint pain and swollen joints other _____ none
- Neurologic problems** numbness weakness, headaches paralysis other _____ none
- Psychiatric problems** depression anxiety other _____ none
- Cancer** benign malignant other _____ none

Do you take any *pills*?

Name of Medicine	Dose	For what condition	How often
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you take any eye *drops or ointments*?

Name of Medicine	Dose	For what condition	How often
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have **ALLERGIES** to any medicines?

Name of Medicine	Describe reaction	Name of Medicine	Describe reaction
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

I authorize the release of medical records, X-rays, pathology reports or pathology slides to Vision Partners, LLC, Mobile Alabama. (Please fax to 251-650-1010). I further authorize the use of my photograph(s) for teaching and/or educational purposes.

 Patient Signature

 Doctor Signature

 /today



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Patient's Name _____ Sex: _____ Marital Status _____ Race _____

Address: _____

Apt# _____

City: _____ State: _____ Zip Code: _____

Home Phone _____ No. SS# _____ Date of Birth: _____

Email _____/Email _____ @ _____

Your *Primary Medical* Doctor _____ *Referring Doctor* _____

Responsible Party (Name: Self, Spouse or Parent/Guardian)

Name: _____ SS# _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Place of Employment (Self or Parent) _____ Phone # _____

Occupation (Patient): _____

Place of Employment (Spouse) _____ Phone # _____

In case of emergency:

Relative's Name _____ Relationship _____ Phone # _____

Friend's Name _____ Phone # _____

Insurance Information:

Primary Insurance Company: _____ Policy # _____

Group # /UDF3 _____ Insured Name on Card: _____ Insured Date of Birth: _____

Relationship to Patient: _____

Secondary Insurance Company: _____ Policy # _____

Group # _____ Insured Name on Card: _____ Insured Date of Birth: _____

Relationship to Patient: _____

If Accident Related give **DATE OF ACCIDENT** _____

Was it a work related accident? Yes ___ No ___

PLEASE COMPLETE THE BACK OF THIS FORM



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FINANCIAL RESPONSIBILITIES:

The undersigned, in consideration of medical services to be rendered Vision Partners, LLC to the above named patient, does hereby agree to pay Vision Partners, LLC on demand of said services and incidentals incurred on behalf of such patient.

Accounts not paid in full are subject to an interest charge.

Authorization for Release of Medical Information:

The hospital and attending physician are authorized to release any medical information required in the processing of application for financial coverage for all services rendered to the patient.

Assignment of Insurance Benefits:

I hereby authorize direct payment of medical benefits to the attending physicians or to whomever he designates. I understand that I am personally responsible to the physician for all charges for services.

I acknowledge that I received a copy of Vision Partners Notice of Privacy Practices

→ **PATIENT SIGNATURE:** _____
RELATIONSHIP TO PATIENT _____
DATE _____

I have read the informational sheet about dilation (available at the front desk) and hereby authorize the doctor and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition

→ **PATIENT SIGNATURE:** _____
RELATIONSHIP TO PATIENT _____
DATE _____

MEDICARE & MEDICARE COMPLETE PATIENTS

Statement to Permit Payment of Medicare Benefits to Provider, Physicians and Patient

Payment for services rendered is to be made as follows: "I request that payment of authorized Medicare benefits be made either to me or on my behalf to Vision Partners, LLC for any services or items furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT SIGNATURE: _____ **DATE:** /Today

