PATIENT INFORMATION

PATIENT NAME: _____
LAST FIRST MIDDLE

MAILING ADDRESS: _____

ZIP CODE: _____ CITY: _____ STATE: _____ E-MAIL _____

HOME PHONE #: (____) _____ WORK PHONE #: (____) _____

DATE OF BIRTH: ____/____/____ CELL PHONE #: (____) _____

MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED DIVORCED WIDOWED OTHER

PATIENT RELATIONSHIP TO RESPONSIBLE PARTY: SELF SPOUSE CHILD OTHER SEX: MALE/FEMALE

PRIMARY CARE PHYSICIAN: _____ LAST EYE EXAM? _____

RACE: _____ PREFERRED LANGUAGE: _____

PATIENT'S EMPLOYER INFORMATION: COMPANY: _____ CITY: _____

RESPONSIBLE (OR INSURED) PARTY INFORMATON

RESPONSIBLE PARTY NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____

DATE OF BIRTH: ____/____/____ SOCIAL SECURITY NUMBER: _____ SEX: MALE/FEMALE

HOME PHONE #: (____) _____ WORK PHONE #: (____) _____

RESP. PARTY'S EMPLOYER INFORMATION: COMPANY: _____ CITY: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR MEDICARE PATIENTS: Healthcare fraud and abuse have been identified as a national problem costing taxpayers literally billions of dollars each year. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with governemnt rules and regulations regarding Medicare. We strive to achieve the very highest standards of ethics and integrity in performing services for our Medicare and patients.

It is our policy to properly determine accurate compensation for our services in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper Medicare expenditures. As part of this plan we have implemented a Compliance Program that we believe will help us prevent any Medicare service or billing errors.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an even in any way compromises our policy of integrity. More so, we welcome your input regarding any billing or service problem so that we may remedy the situation promptly.

INSURANCE RELEASE

I authorize my doctor to act as my agent in helping me in obtain payment of my insurance benefits, and I authorize payment of these benefits directly to Todd A. Hackney, O.D. on my behalf for any services and materials furnished. I understand that I am financially responsible for all charges whether or not by paid insurance.

I acknowledge that I have received a copy of the Privacy Practices for Todd A. Hackney, O.D.

_____ _____
Signature Date

HEALTH HISTORY

SOCIAL HISTORY: HEIGHT: _____ WEIGHT: _____

DO YOU USE TOBACCO PRODUCTS? ☐ YES ☐ NO IF YES, AMOUNT/HOW LONG? _____

DO YOU USE DRINK ALCOHOL? ☐ YES ☐ NO IF YES, AMOUNT/HOW LONG? _____

YES	NO		YES	NO	
☐	☐	Asthma _____	☐	☐	Head or Spinal Injuries _____
☐	☐	Kidney Disease _____	☐	☐	Seizures, Convulsions, or Fainting _____
☐	☐	Tuberculosis _____	☐	☐	Extensive Confinement by Illness or Injury _____
☐	☐	DIABETES IDDM/Type II - # of years _____	☐	☐	Temporal Arteritis _____
☐	☐	Insulin _____	☐	☐	Suffering from any other disease _____
☐	☐	Migraines _____	☐	☐	Carotid Artery Disease _____
☐	☐	Psychiatric Disorder _____	☐	☐	Permanent defect from illness, disease or injury
☐	☐	Any Nervous Disorder _____	☐	☐	Women (Are you pregnant?) _____
☐	☐	Heart Disease _____	☐	☐	Stroke _____
☐	☐	Ulcer _____	☐	☐	HIV _____
☐	☐	Hypertension _____	☐	☐	Other Diagnosed Health Problems _____
☐	☐	Sickle Cell Anemia _____			

Please List ALL Medication/Vitamins You Are Taking:	Please List All Allergies:

YOUR OCULAR HISTORY *(Have you been diagnosed with any of the following the past?)*

YES	NO		YES	NO	
☐	☐	Cataracts _____	☐	☐	Cornea Disease _____
☐	☐	Retina Disease _____	☐	☐	Glaucoma _____
☐	☐	Crossed Eyes _____	☐	☐	Injury _____
☐	☐	Iritis _____	☐	☐	Other Eye Disorders _____

Cataract Surgery (Date of Surgery) Right Left Do you have a lens implant? ☐ Yes ☐ No

Retina Surgery (Date of Surgery) Right Left Lasik/Refractive Surgery (Date of Surgery)

Explanation of Eye Injury:

FAMILY HISTORY *(Has anyone in your family (blood relative) had any of the following)*

(NOTE RELATION TO PATIENT)

YES	NO		YES	NO	
☐	☐	Glaucoma _____	☐	☐	Diabetes IDDM/Type II _____
☐	☐	Cataracts _____	☐	☐	Heart _____
☐	☐	Cornea Disease _____	☐	☐	Diabetic Retinopathy _____
☐	☐	Macular Degeneration _____	☐	☐	Retinal Detachment _____
☐	☐	Retinitis Pigmentosa _____	☐	☐	Stroke _____
☐	☐	Other Eye Problems _____	☐	☐	Other General Health Problems _____