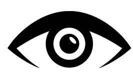

NORTH ALABAMA EYE CARE

GREGG P. MOODY M.D., P.C.

PERSONAL INFORMATION (Please Print)

Name ______________________________ Date ______________

Date of Birth ____________ Age _____ ☐ M / ☐ F Social Security #______________

Address ____
Street City State Zip

Phone: Home (____) ______________ Work (____) ______________

Occupation ______________________ Employer ______________________

Address ______________________________ Phone (____) ____________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse Name ______________________ Employer ______________________

Address ______________________________ Phone (____) ____________

Complete if under 18 years or a student

Name of Father ______________________ Employer ______________________

Address ______________________________ Phone (____) ____________

Name of Mother ______________________ Employer ______________________

Address ______________________________ Phone (____) ____________

Referred by: ☐ Friend/Relative ________________ ☐ Doctor ________________
Name Name

☐ Yellow Pages ☐ Television ☐ Newspaper ☐ Other ____________________

INSURANCE INFORMATION

☐ Medicare #______________________ ☐ Medicaid # ______________________

☐ Workers Compensation (job injury) to whom is bill to be sent? ______________________

☐ Other Medical Insurance ______________________________________

Group # ____________________ ID #____________________

Name/Address 2nd Insurance ______________________________________

Are you personally responsible for the payment of your fees? ☐ Yes ☐ No If not, who is?

Name ______________________ Relationship ______________ DOB ____________

Who to notify in emergency (nearest relative or friend)?

Name ______________________________ Relationship ____________________

Address ____
Street City State Zip

Home Phone: (____) ______________ Work Phone: (____) ______________

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. Refraction charge of $20 WILL NOT be covered by insurance.**
2. **In Order To Control Your Cost of Billings, We Request That Your Charges For Office Visits Be Paid At The Conclusion Of Each Visit Unless You Are Covered By Medicare.**
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. 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 the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed (Patient or parent if minor) ______________________________ Date ______________

PATIENT HISTORY FORM

Patient Name ____ Date __________________

Birth Date ____________________ Referred by ____

REVIEW OF SYSTEMS Do you currently have any of the following problems?		
		If YES, please explain.
1. Please list medication you are taking, including eye drops.		
2. Do you have any allergies to any medication?	☐ Yes ☐ No	
3. **Constitutional** (fever, weight loss, other)	☐ Yes ☐ No	
4. **Eyes** (glaucoma, cataract, lazy eye, retina problems, other - please specify)	☐ Yes ☐ No	
5. **Ear / nose / mouth / throat** (hearing loss, sinus problems, sore throat)	☐ Yes ☐ No	
6. **Cardiovascular** (heart problems, chest pain, irregular heart beat)	☐ Yes ☐ No	
7. **Respiratory** (asthma, shortness of breath, wheezing, coughing)	☐ Yes ☐ No	
8. **Gastrointestinal** (heartburn, abd. pain, diarrhea, vomiting)	☐ Yes ☐ No	
9. **Genitourinary** (urinary problems, blood in urine)	☐ Yes ☐ No	
10. **Integumentary** (skin rashes, excessive dryness)	☐ Yes ☐ No	
11. **Musculoskeletal** (muscle aches, joint pain, swollen joints)	☐ Yes ☐ No	
12. **Neurological** (numbness, weakness, headaches, paralysis)	☐ Yes ☐ No	
13. **Hematologic/Lymphatic** (blood disorders, leukemia)	☐ Yes ☐ No	
14. **Allergic/Immunologic** (hay fever, allergies)	☐ Yes ☐ No	
15. **Endocrine** (thyroid problems)	☐ Yes ☐ No	
16. **Psychiatric** (depression, anxiety)	☐ Yes ☐ No	

Family and social history: Do any medical or eye diseases run in your family. If YES, Please note relationship to patient.

☐ Glaucoma	________________			
☐ Diabetes	________________	Do you smoke? If YES, how much?	☐ Yes	☐ No
☐ High blood pressure	________________	How much:	________________	
☐ Macular degeneration	________________	Drink alcohol? If YES, how much?	☐ Yes	☐ No
☐ *Other*	________________	How much:	________________	

Comments: ____

Physician's Signature: ____ *Date:* __________________

PATIENT HISTORY RECORD

▲ DATE (MM/DD/YY) ▲ REFERRED BY ▲ BIRTH DATE

▲ PATIENTS NAME ▲ SEX ▲ AGE

▲ ADDRESS ▲ PHONE (H)

▲ EMPLOYER ▲ OCCUPATION ▲ PHONE (W)

▲ SOCIAL SECURITY NUMBER ▲ PRIMARY CARE PHYSICIAN

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc)
   Yes ☐ No ☐ If YES, please explain: ____________________
2. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
   Yes ☐ No ☐ If YES, please explain: ____________________
3. Have you ever had any surgery?
   Yes ☐ No ☐ If YES, please provide date and reason: ____________________
   ____
4. Have you ever been hospitalized?
   Yes ☐ No ☐ If YES, please provide date and reason: ____________________
   ____
5. Do you take any medications?
   Yes ☐ No ☐ If YES, list: ____________________
   Do you take any eye medications?
   Yes ☐ No ☐ If YES, list: ____________________
6. Do you have any drug or food allergies?
   Yes ☐ No ☐ If YES, list: ____________________

Review of Systems

Do you currently have any of the following problems?

	Yes	No	If YES, please explain
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	
Ear/nose/throat problems **(e.g., hearing loss, sinus problems, sore throat)**	☐	☐	
Heart problems **(e.g. chest pain, irregular heart beat)**	☐	☐	
Respiratory problems **(e.g., shortness of breath, wheezing, coughing)**	☐	☐	
Gastrointestinal problems **(e.g. heartburn, abdominal pain, diarrhea, vomiting)**	☐	☐	
Urinary problems **(e.g. pain or discomfort, blood in urine)**	☐	☐	
Skin problems **(e.g. rashes, excessive dryness)**	☐	☐	
Musculoskeletal problems **(e.g., muscle aches, joint pain, swollen joints)**	☐	☐	
Neurologic problems **(e.g., numbness, weakness, headaches, paralysis)**	☐	☐	
Psychiatric problems **(e.g., depression, anxiety)**	☐	☐	

Family and Social History

Do any medical or eye diseases run in your family *(e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)*
Yes ☐ No ☐ If YES, please explain: ____________________
____

Do you smoke? If yes, how much? ____________ Drink alcohol? If yes, how much? ____________

If employed, how many hours per week do you work? ____________

▲ **Comments**

▲ **M.D. Signature** ▲ **Date**

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