PRIMARY EYECARE & OPTICAL OF MERIDIAN

Today's Date:

PATIENT INFORMATION

Patient Name: (First) (Middle Initial) (Last) **Birthdate:** - -

Address: City: State: Zip:

Sex: ( ) M ( ) F **Height:** **Weight:** **Age:** **Race:** **Social Security #**

Home Phone: ( ) Day Phone: ( ) Cell Phone: ( )

(Can we text you?) Yes No

e-mail address

Employer/School: Occupation/Grade: Work Phone: ( )

Spouse's Name: Phone: ( )

(If minor) Father's/Mother's Name: Phone: ( )

In case of emergency, contact: Relationship: Phone: ( )

PARENT or SPOUSE or PRIMARY INSURED if different from patient

Name:
First Middle Last

Social Security #:

Birthday: Day Phone: ( )

Address: (if different from patient)

City: State Zip

Place of employment:

Position:

INSURANCE

Primary Medical Insurance (Includes Medicare & Medicaid)

Plan Name:

ID Number:

Secondary Medical Insurance:

Plan Name:

ID Number:

Vision Insurance:

Plan Name:

ID Number:

REASON FOR TODAY'S VISIT

PRIMARY CARE PHYSICIAN

PCP Name:

Telephone:

EYE HEALTH HISTORY

Date of last eye exam:

Where:

Do you wear glasses? ( ) Y ( ) N

Do you wear contacts? ( ) Y ( ) N

Contact lens brand:

Do you sleep in contacts? ( ) Y ( ) N

How long (hrs)?

Name & Location of Drug Store:

FAMILY MEDICAL HISTORY

Do you or your immediate family have the following conditions?
If so, indicate relationship:

Glaucoma	( ) Y ( ) N	
Blindness	( ) Y ( ) N	
Cataract	( ) Y ( ) N	
Crossed Eyes	( ) Y ( ) N	
Macular Degeneration	( ) Y ( ) N	
Heart Disease	( ) Y ( ) N	
High Blood Pressure	( ) Y ( ) N	
Diabetes	( ) Y ( ) N	

Primary Eyecare & Optical of Meridian, P.A.

4721 26th Avenue
Meridian, MS 39305
601.485.2020

CONSENT FOR TREATMENT & FINANCIAL AGREEMENT

PATIENT'S NAME_____DATE_____

Referred by: _____

INITIAL EACH:

_____ I consent to treatment necessary or desirable for the care of the patient mentioned above, including but not restricted to, dilation drops, pharmaceutical agents, and/or surgical procedures that may be used by the attending doctor of optometry, technician, or qualified designate.

Dilation of your eyes is necessary to obtain the best view of your retina, but can cause blurred vision and/or glare for several hours. We recommend that you do not drive for the first few hours following dilation. You may return for this dilation on another date, use our phone to call someone to pick you up, or you may stay until the dilation effects have worn down.

_____ I have read this information about dilation and fully understand that driving may not be safe for me or for others. If I choose to drive after dilation, I do so at my own risk and Primary Eyecare & Optical will in no way be held responsible.

_____ **I understand that contact fittings are an extra procedure that is performed with the yearly exam; and that additional fees that may not be covered by most insurances, will be charged to the patient. The price of a contact fitting covers the trial lenses and training in insertion & removal of contacts and the care & maintenance of contacts and any follow/up visits needed for a 30 day period.**
Additional fees may apply after 30 days.

_____ I have provided ALL insurance information/cards to this office. I also understand that this office may or may not be in-network for my insurance and for that, I will be responsible for ANY and/or ALL services provided that my insurance may or may not cover.

_____ I understand that the patient or responsible party is **solely responsible** for payment of all services, although the insurance carrier may be billed for said services. If this account becomes overdue, I agree to pay all costs of collection, including any legal fees.

_____ I understand that some services are not always covered as dictated by my insurance company based on the medical necessity. I understand that if any treatment is rejected by my insurance plan as a non-covered procedure, **I will be billed for those services.** I acknowledge as a member of these plans that this office will submit my insurance claim and **I will be responsible for paying all co-pays and/or deductibles at the time of the visit.**

_____ **I authorize my insurance company to remit payment of benefits directly to this office for services provided.**

_____ I hereby authorize the release of all medical records on the patient listed above to the referring and family physicians, as well as all necessary records for the processing of insurance claims.

HIPAA Acknowledgement. I have read and understood the HIPAA Privacy Practices.
_____ ***(Please see attachments).***

Print Name of Responsible Party: _____Date:_____
(must be 18 or older)

Signature of Responsible Party: _____Date:_____

Witness Signature: (PEOM employee)_____Date:_____