

Schulze Eye Center, P.C.
Patient Information

Date _____

How did you hear about us? (circle one) Friends/family TV Radio Newspaper Yellow Pages Internet

Referred by Doctor _____

Patient's Name _____

Address _____

City _____ State _____ County _____ Zip _____

Home Phone () _____ Work Phone () _____ Cell Phone () _____ e-mail _____

Birthday _____ Age _____ Social Security # _____

Marital Status: Single _____ Widowed _____ Married _____ Divorced _____

Employer _____

Employer's Address _____

City _____ State _____ Zip _____

Medicare # _____ **Medicaid #** _____

Name of Insurance Company (Primary) _____

Name of policy holder (if other than yourself) _____

Social Security # _____ DOB _____

Insurance Company Address _____

Policy # _____ Group # _____

Insurance Co. Mailing Address _____

Name of Insurance Company (Secondary) _____

Name of policy Holder (if other than yourself) _____

Insurance Company Address _____

Policy # _____ Group _____

Insurance Co. Mailing Address _____

Spouse Information

Name _____ DOB _____ Social Security # _____

Place of Employment _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Emergency Contact (not in the same household) _____

Relationship _____ Address _____

City _____ State _____ Zip _____ Phone () _____

Person (s) That we may talk with on your behalf regarding appointments, medicines, questions about care, etc.

Name and Relationship _____

I hereby release to my insurance company any information required for services provided and I authorize payment of medical benefits to Schulze Eye Center, P.C. I also understand that I remain responsible for any and all charges not met by my insurance company.

Signature _____ Date _____

Schulze Eye Center

Date ____/____/____ Name _____

Please complete: Have you ever been known to have (Please circle yes or no):

Cardiovascular Problems:

High blood pressure yes no
Heart trouble yes no
Heart Attack yes no
Congestive heart failure yes no
Irregular/fast heartbeat yes no
Stroke yes no

Eye Problems:

Cataract yes no
Glaucoma yes no
Macular Degeneration yes no
Eye Injury yes no
Previous eye surgery yes no
Lazy eye yes no
Uveitis (inflammation) yes no

Lung or breathing Problems:

Asthma yes no
Emphysema yes no
COPD yes no

Other:

Arthritis yes no
Kidney disease yes no
Cancer yes no
HIV yes no
Hepatitis yes no

Endocrine

Diabetes yes no

Surgical procedures you have had (please circle)

Tonsillectomy Heart Prostate Appendectomy Cataract
Hernia repair Gallbladder Stomach Hysterectomy
Other: _____

Please list Medications you are presently taking: (Please list below)

Are you allergic to any medications ? YES

NO (if yes, please list below)

Family history: Has anyone in your immediate family (Father, Mother, Sister, Brother) ever had?:

Cataracts Glaucoma Macular degeneration Diabetes Heart disease Cancer

Social history: Do you use any type of tobacco products? Yes No Type _____

Do you drink alcohol? Yes No How much? _____ How often? _____

For our cataract patients: We now have the technology to make our cataract patients less dependent on glasses and contact lenses for both distance and reading vision with the use of multifocal intraocular lenses. Unfortunately, Medicare and private insurers do not cover the costs of these lenses, which are available for an additional fee. Are you interested in this technology? *Yes No* (circle one)

Schulze Eye & Surgery Center
728 E. 67th St.
Savannah, Ga. 31405

Patient Consent Form

Our Notice of Privacy Practice provides information about how we may use and disclose protected health information about you. The notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing the consent. The terms of the notice may change. If our notice changes you may obtain a revised copy by contacting our office. You have the right to restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do we shall honor that agreement.

By signing this form you consent to our use and disclosure of Protected Health Information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing signed by you. However such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment or health care operations.

The Practice and or Facility has a Notice of Privacy Practices and that the patient has the opportunity to review the Notice.

The Practice and or Facility reserve the right to change the Notice of Privacy Policies.

The patient has the right to restrict the uses of their information but the Practice does not have to agree with those restrictions.

The patient may revoke this consent in writing at any time and all future disclosures will the cease.

The Practice and or Facility may condition treatment upon the execution of this consent.

Date: _____

Consent signed by: _____
Print Name Signature

Relationship to Patient if other than patient _____

Witness _____
Print Name Signature