



Drs. Whitley and Hughes

Welcome To Our Office

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell# _____ Responsible Party, if other than patient

Home# _____ Name: _____

Work# _____ Address: _____

Employer or School: _____ Phone: _____ Date of Birth: _____

Date of Birth: _____ Sex: Male or Female Social Security#: _____

Spouse: _____ Vision Insurance: _____

Date of Birth: _____ Medical Insurance: _____

Social Security# _____ Primary Care Physician: _____

Employer: _____ Address: _____

Cell# _____

Assignment and Release

I, the undersign, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Drs. Whitley and Hughes all insurance benefits, if any, otherwise payable to me for service rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the use of this signature on all insurance submissions.

Patient Signature _____ Date _____

- Have you ever worn or are you currently wearing glasses/contact lenses? Yes or No
- Are you interested in glasses/contact lenses? Yes or No
- Are you interested in information concerning laser vision correction? Yes or No
- Do you have prescription sunglasses? Yes or No

For the purpose of notifying me of my protected health information such as test results, appointments dates and times, or other necessary contacts. This person or persons will only be notified when I cannot be reached. I _____ permit Whitley and Hughes to contact

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Medical Authorization

I request that payment of authorized Medicare benefits be made on my behalf to Drs. Whitley and Hughes for services furnished to me by Drs. Whitley and Hughes. I authorize any holder of medical information about me be released to the Division of Medicare and Medicaid Services and its agents and any information needed to determine those benefits payable for related services. **I understand my signature requests that payment be made and authorizes release of medical information necessary to pay claim.** If "other health insurance" is indicated in item 9 of HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of their information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature _____ Date _____

Name: _____ Date: _____ Date of Birth: _____

Circle any of the following medical conditions that you currently have

Medical Health

- | | | |
|---|-------------------------|------------------|
| Allergies | Coronary Artery Disease | Hyperthyroidism |
| Anemia | Depression | Hypothyroidism |
| Anxiety | Diabetes | Kidney Disease |
| Arthritis | Emphysema | Leukemia |
| Asthma | GERD | Liver Disease |
| Atrial Fibrillation (Irregular Heartbeat) | Hearing Loss | Lung Cancer |
| High Blood Pressure | Heart Disease | Lymphoma |
| Breast Cancer | Headaches/Migraines | Prostate Cancer |
| Bronchitis | Hepatitis | Radiation |
| Colon Cancer | HIV/AIDS | Seizures |
| COPD | High Cholesterol | Sinus Congestion |
| | | Stroke |

Other: _____

Patient Medical Surgery History: _____

Smoking History: Current _____ Former: _____ Never: _____

Circle any of the following ocular conditions that you currently have

Ocular Health

- | | |
|-------------------------|----------------------|
| Blurry Vision | Glaucoma |
| Burning | Itching |
| Cataract(s) | Lazy Eye |
| Crossed eyes | Loss Vision |
| Double Vision | Macular Degeneration |
| Dry Eyes | Retinal Disease |
| Flashes/Floaters | Styes or Chalazion |
| Glare/Light Sensitivity | |

Other: _____

Patient Ocular Surgery History: _____

