Drs. Whitley and Hughes

Welcome To Our Office

Name:_____ Date:_____

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

Cell#_____

Home#_____

Work#_____

Employer or School:_____

Date of Birth:_____

Sex: Male or Female

Social Security#:_____

Spouse:_____

Date of Birth:_____

Social Security#_____

Employer:_____

Cell#_____

Responsible Party, if other than patient

Name:_____

Address:_____

Phone:_____Date of Birth:_____

Social Security#:_____

Vision Insurance:_____

Medical Insurance:_____

Primary Care Physician:_____

Address:_____

Have you ever worn or are you currently wearing glasses/contact lenses? Yes_____ No_____

Are you interested in glasses/contact lenses? Yes_____ No_____

Are you interested in information concerning laser vision correction? Yes _____ No_____

Do you have prescription sunglasses? Yes _____ 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: _____

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 em 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_____

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.**

Name:_____ Date:_____ Date of Birth:_____

Circle any of the following medical conditions that you currently have

Medical Health

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

Coronary Artery
Disease Depression
Diabetes Emphysema
GERD
Hearing Loss
Heart Disease
Headaches/Migraines
Hepatitis
HIV/AIDS
High Cholesterol

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

Other:_____

Patient Ocular Surgery History:_____

Name:_____ **Date of Birth:**_____

Current Medications

Please list all medications you are currently taking including over the counter

Medication	Dosage	Frequency

Current Medication Allergies: Yes/No
If Yes, please list below

Family History WHO/WHAT

	Mother	Father	Sibling	GM/GF
Heart Disease				
Hypertension				
Diabetes				
Cataracts				
Glaucoma				
Blindness				
Lazy Eye				
Macular Degeneration				
Other:				
Other:				

Please sign below confirming that all information above is correct to the best of your knowledge

Patient Signature:_____ **Date:**_____