WELCOME

GALLAHER EYECARE

DATE___________________________________

Last Name: ____

First Name: ______________________________ M.Initial: ________

Nickname: ______________________________

Address: ____
Street Address Apt#

____
City/State Zip

Phone: ____
Home Daytime Cell

Texting ok? YES / NO

____
Pager Fax

EMAIL Address: ____

How did you hear about us?
Friend/Family Name ______________________________
Yellow Pages /Newspaper/ Insurance
Other:____

Sex: Male / Female

Date of Birth: ______________________ Age:________

Social Security #: ______________________

Marital Status: Single / Married / Divorced / Widowed

Employment Status: Full-time / Part-time / Unemployed / Retired

Full-Time Student
Yes / No

Employer: ______________________________

Occupation: ______________________________

Preferred Language: English / Spanish / Other ______________

Race: American Indian / Asian / Black or African American / Caucasian / Hispanic /
Native Hawaiian or Oth Pacific Isl.

Ethnicity: Hispanic or Latino / Native Hawaiian/Oth Pacific Isl. / Not Hispanic or Latino

Communication Preference: Phone / Text / Email

Emergency Contact Information:
Name: ____ Relationship:________________
Telephone:____

INSURANCE INFO

Vision Insurance: NO / YES **Medical Insurance: NO / YES**

Plan Name_______________________________
ID#____________________________________

***Insured's Name________________________
Insured's Date of Birth________________________
Insured's Soc Sec #_______________________

Primary Plan Name____________________________
(Medicare, Blue Cross, Etc.)
ID#____________________________________
Group# ___________
***Insured's Name________________________
Date of Birth_____________________________

Secondary Ins Plan Name: ______________________
ID#_________________
Group#_________
***Insured's Name ____________________________
Date of Birth___________________________________

Workman's Compensation: NO / YES: Contact at Work: Name _____________________________
Telephone____

Party Responsible for Account:

Name:_____________________________
Relationship: _______________________
Address: __________________________
Telephone: _________________________
Date of Birth:_______________________
Social Security #:____________________

What is the reason for this visit? ____

Family Physician:____

Medical History

Check all that apply to you:

□ Arthritis
□ Asthma
□ Breathing Problems
□ Bronchitis
□ Emphysema
□ Hayfever/Allergies
□ Headaches/Migraines
□ Tremors, Parkinson’s
□ Convulsions, Epilepsy
□ High Cholesterol
□ High Blood Pressure
Duration: ______________
□ Heart Attack

□ Chest Pain, Angina
□ Other Heart Problems
□ Swelling Ankles
□ Kidney Problems
□ Thyroid Disorders
□ Hepatitis, Liver Disease
□ Cancer
□ Stroke
□ Diabetes Mellitus
Duration: ______________
□ Insulin □ Pills
□ Other:_______________________

□ NONE OF THE ABOVE

Past **Medical** Surgeries: ____
____
____
____

□ NO PREVIOUS MEDICAL SURGERIES

Past **Ocular** (Eye) Surgeries: ____
____

□ NO PREVIOUS OCULAR SURGERIES

Check all that apply to:

You		Relatives
□	Cataracts	□
□	Glaucoma	□
□	Retinal Tear	□
□	Amblyopia, Lazy Eye	□
□	Crossed Eyes	□
□	Color Blindness	□
□	Retinal Degeneration	□
□	Other _____________	□
□	Other _____________	□
□	Other _____________	□

Do you have, or do you see, any of the following?

□ Burning	□ Night Blindness	□ Nausea
□ Redness	□ Flashes of Light	□ Pain
□ Dryness	□ Headaches	□ Tearing
□ Spot	□ Floaters	□ Itching
□ Gritty Sensation	□ Double Vision	□ Blurred Vision
□ Sensitivity to Light	□ Sudden Loss of Vision	□ Fainting & Dizziness

Do you smoke? __Yes __No Do you drink alcohol? __Yes __No

Current Medications (Rx or Over the Counter)
____
____
____
____

□ NO CURRENT MEDICATIONS

***Medication* Allergies**: ______ ____
____

□ NO KNOWN DRUG ALLERGIES

Gallaher EyeCare

MEDICARE and COMMERCIAL INSURANCE AUTHORIZATION WAIVER FORM – SIGNATURE ON FILE

FOR OUR MEDICARE PATIENT / WAIVER OF LIABILITY

I request payment of authorized Medicare benefits be made on my behalf to GALLAHER EYE CARE for any covered services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand Medicare will not cover any services determined as routine/screening. I understand that I will be financially responsible for these charges. These services include refraction, routine eye exams, glasses and contact lens (with the exception of the one covered pair after each eye cataract surgery or aphakic patients), replacements, non-medically necessary tints, scratch coats, other additional patient options for glasses, contact lens cleaners and solutions. Other non-covered services by the Medicare program include low vision exams, low vision aids, Emergency, Office, Unusual Hours, and Medical Service Night.

MEDICARE/MEDIGAP BENEFITS

I request that payment of authorized Medigap benefits be made either to me or on my behalf to GALLAHER EYE CARE for any services furnished to me. I authorize any holder of medical information about me to release to ______________________________any
(Name of Medigap Insuror)
information needed to determine these benefits of the benefits payable for related services.

These assignments will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signed:____ Date:___________________
(Patient or Guarantor)

OUR NON-MEDICARE PATIENT / ACCEPT ASSIGNMENT

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all vision, medical and/or post-op surgical benefits including major medical benefits to which I am entitled to GALLAHER EYE CARE. This assignment will remain in effect until revoked by me in writing. Photocopy of this assignment is to be considered as valid as the original. I understand I will be financially responsible for non-covered services and charges.

Signed:____ Date:___________________
(Patient or Guarantor)

Gallaher EyeCare

Our Notice of Privacy Practices 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. Our office provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You have the right to review our Notice before signing this Consent. You have the right to request that we restrict how 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 terms of our Notice may change. If we change our Notice – you may obtain a revised copy by contacting our office.

The patient understands that:

- The Office has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Office reserves the right to change the Notice of Privacy Policies
- The Patient has the right to restrict the uses of their information unless the Office is required to disclose the information by law
- The patient may revoke this Consent – in writing – at any time
- The Office may condition treatment upon the execution of this Consent

This Consent was signed by ____
(Patient or Representative)

Relationship to Patient (if other than patient) ___________________________________

Date ________/________/_________

Witnessed by___________________________________
(Office Representative)