Welcome to our Office!

PLEASE PRINT ALL INFORMATION

First Name: _____ **Middle Initial:** _____ **Last Name**:_____

Preferred name: _____ **Date Of Birth**: ___/_____/_____**SSN**:_____-_____-____

Mailing Address: _____ **City:** _____ **State:** _____**Zip**: _____

Primary Phone#: _____ **Secondary Phone/Message#**: _____ **EMAIL**: _____

Sex: ❑Male ❑Female**Language:** ❑English ❑Spanish **Ethnicity:** ❑Hispanic ❑Not Hispanic **Race:** ❑Black/African American ❑White ❑Asian ❑Other:_____

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed **Spouses Name: _____DOB:**_____

RESPONSIBLE PARTY (If under 18)

NAME:_____**DOB:**_____ **SSN:**_____ **Relationship to Child:**_____

Emergency Contact (If over 18):_____ **TELEPHONE #:**_____**Relationship:** _____

Acknowledgment of Notice of Privacy Practices/Release of Information

The law requires that Corinth Eye Clinic, Inc make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

I have been given the opportunity to read, have read, or had explained to me prior to any services offered Corinth Eye Clinic, Inc's Notice of Privacy Practice and agree to continue my care with Corinth Eye Clinic, Inc under said terms.

By signing below I authorize the release of information about my health and/or appointments to the following people who are not my doctors or insurance providers.

This signature on file is also my authorization for the release of information necessary to process my insurance claim. I hereby authorize payment to this doctor or office named of the benefits otherwise payable to me. This signature may be used for all insurance claims unless revoked in writing.

Information may be released to:

1) _____ Name/Relationship

2) _____ Name/Relationship

[ ] INFORMATION IS NOT TO BE RELEASED TO ANYONE. This release may remain in effect until revoked in writing.

CANCELLATION AND NO SHOW POLICY

At Corinth Eye Clinic our goal is to provide quality eye care in a timely manner. No shows and late cancellations inconvenience those individuals who need access to timely medical care. This policy enables us to better utilize available appointments for our patients in need of eye care.

LATE CANCELLATION AND NO SHOW POLICY

A cancellation is considered late when a patient contacts CEC to cancel their scheduled appointment with less than 24 hours advance notice.

A no show is determined when a scheduled patient misses their appointment without contacting CEC. A failure to be present at the time of a scheduled appointment without a call canceling the appointment will be recorded in your medical record as a no show.

If a patient no shows or fails to provide 24 hour notice, they will be subject to a $25 scheduling fee which will be collected up front prior to next appointment.
The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours and in such instances, we will waive the fee upon management approval.

CANCELLATION OF AN APPOINTMENT
In order to be respectful of the eye care needs of all our patients, please be courteous and call CEC 24 hours in advance if you are unable to show up for an appointment. We understand that things come up and it may not be possible for you to keep your scheduled appointment.

HOW TO CANCEL YOUR APPOINTMENT
If canceling an appointment, please call or text 662-286-8860. If you do not reach a representative that can assist, you may leave a detailed message and someone will contact you in a timely manner.

Fees & Payments

We make every effort to keep down the cost of your medical care. You can help by paying in full upon the completion of each visit. If you have any vision and/or medical insurance we will be glad to fill out the proper forms or file the claim for you, but please complete the identifying information within this paperwork.

If you are using insurance coverage for today's visit--this is a contract between you and your insurance company, not Weeden Eye Clinic, Inc., or Dr. Michael Weeden. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures or items and others pay a percentage of the charge. It is your responsibility to know the terms and limitations of your policies.

For patients with BOTH medical and Vision coverage, your vision insurance is intended to provide you with a baseline eye exam. If you are being evaluated for medical reasons (corneal disorders, diabetes, cataracts, glaucoma suspect, double vision, etc.), you are being provided with medical care. Typically your vision company does not provide coverage for medical care. Therefore, we will file a claim with your medical insurance for visits related to medical complaints and problems.

I certify that the insurance information that is on this form or provided to this office is accurate. I understand I am financially liable for any deductible amount, co-insurance & non-covered services or any other balance not paid by my insurance company(s). I understand that you may bill me if my insurance company takes longer than 90 days to pay your office. If my insurance company denies payment, I agree to be personally responsible for payment. If I have no insurance, I understand that I am responsible for the entire balance of services and products provided. I will be responsible for all collection costs, attorney's fees, and court costs should my account be turned over to collection. I certify that I understand there are no refunds or exchanges and that all sales are final unless covered under manufacturer or office warranty programs.

THIS SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST MY MEDICAL RECORDS BE SENT TO/FROM ANOTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

SIGNED:_____ DATE:_____

(Signature of Patient if over 18, Parent or Guardian if minor)

WITNESS:_____ DATE:_____

(Office Use Only)

Medical History Questionnaire

Name: _____ DOB: ___/___/___

Medical History:

Do you have any allergies to medications? ❑ No ❑ Yes If yes, explain _____

_____

List any **Medications** you are taking (including oral contraceptives, aspirin, over the counter medications and home remedies). If you would prefer we request your medications from the Pharmacy please select YES and write name of Pharmacy below along with the location:

_____

_____

_____

Have you had any surgical procedures on your eyes? Please list in detail:

_____

_____

_____

Family History:

Please note any family history (Parents, Siblings, and Children living or deceased for the following medical conditions), all others NOT marked will be considered NEGATIVE:

DISEASE / CONDITION	RELATIONSHIP TO YOU					
Blindness	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Cataract	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Crossed / Lazy Eye	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Glaucoma	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Macula Degeneration	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Retinal Detachment/Disease	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Arthritis	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Cancer	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Diabetes	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Heart Disease	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
High Blood Pressure	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Kidney Disease	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Lupus	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter
Thyroid Disease	❑Father	❑Mother	❑Brother	❑Sister	❑Son	❑Daughter

Below list anything you would like us to know for your eye health records:

_____

_____

_____

Your Medical History: Review Of Systems: Please indicate all of the following POSITIVE medical conditions pertain to you. All unmarked will be considered NEGATIVE.

Constitutional:	**Yes**
Weight Loss	❑
Weight Gain	❑
Cancer	❑

Ears, Nose, Mouth, Throat:	**Yes**
Hearing Loss	❑
Sinusitis	❑
Dry Mouth	❑
Laryngitis	❑
Chronic Cough	❑

Neurologic:	**Yes**
Multiple Sclerosis	❑
Epilepsy	❑
Cerebral Palsy	❑
Tumor	❑
Stroke/CVA	❑
Migraines	❑
Headaches	❑
Autism Spectrum Disorder	❑

Psychiatric:	**Yes**
Depression	❑
Attention Deficit	❑
Anxiety Disorder	❑
Bipolar Disorder	❑
Schizophrenia	❑

Cardiovascular:	**Yes**
High Blood Pressure	❑
Stroke/CVA	❑
Heart Disease	❑
Vascular Disease	❑
Congestive Heart Failure	❑
Hypercholesterolemia	❑

Respiratory:	**Yes**
Cigarette Smoker	❑
Asthma	❑
Emphysema	❑
Chronic Obstruction(COPD)	❑
Sleep Apnea	❑

Gastrointestinal:	**Yes**
Crohn's	❑
Colitis	❑
Ulcer	❑
Acid Reflux	❑
Celiac Disease	❑

Genitourinary:	**Yes**
Kidney Disease	❑
Prostate Disease/Cancer	❑
Herpes	❑
Chlamydia	❑

Muskuloskeletal:	**Yes**
Arthritis	❑
Fibromyalgia	❑
Muscular Dystrophy	❑
Ankylosing Spondylitis	❑

Integumentary:	**Yes**
Eczema	❑
Rosacea	❑
Psoriasis	❑
Herpes Simplex/Cold Sores	❑
Herpes Zoster/Shingles	❑

Endocrine:	**Yes**
Diabetes Type 1	❑
Diabetes Type 2	❑
Thyroid Dysfunction	❑

Lymphatic/Hematologic:	**Yes**
Leukemia	❑
Blood Thinner	❑

Allergic/Immunologic:	**Yes**
Drug Allergies	❑
Environmental Allergies	❑
Rheumatoid Arthritis	❑
Lupus	❑
Sjogren's Syndrome	❑

Eyes:	
Crossed Eye	❒
Lazy Eye	❒
Cataract	❑
Macular Degeneration/ARMD	❑
Glaucoma	❑
Dry Eye	❑
Eye Injury	❑
Floaters/Flashes of Light	❑
Iritis/Uveitis	❑
Retina Defects/Degenerations	❑
Eye Pain	❑
Severe Light Sensitivity	❑
Poor Night Vision	❑
Bothersome Night Glare	❑
Double Vision	❑
Total Loss of Vision	❑

Other:

_____

_____

_____

(OFFICE USE ONLY)

P, F, S Hx Prob Pertient (1area) _____

Complete (2-3 areas) _____

ROS Prob Pertient (1 sys) _____

Ext. (2-9) _____

Complete (>10) _____

☐☐Primary ROS taken today

☐☐Reviewed ___/__/___ ROS & PFSH today

Changes Noted:

Initials: _____ Date: _____

SIGNATURE OF PATIENT

X_____ Date _____