



WELCOME TO THE WOODHAMS EYE CLINIC

Salutation [] Mr. [] Mrs. [] Miss [] Ms. Please Print

Name _____ Age _____ Date of Birth ____/____/____ Sex: [] M [] F
(Last) (Legal First) (M.I.) (Nickname) (Mo) (Day) (Year)

Address _____ Email Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____

Social Security # _____ Marital Status - [] Single [] Married [] Divorced [] Widowed

Spouse Name _____

Employer _____ Phone (_____) _____

Occupation _____ Sports or Hobbies: _____

In case of an emergency, whom should we contact? _____ Phone _____

How did you hear about us? Check as many that apply:

[] Radio (station) _____ WHEN DID YOU HEAR THE AD? _____

[] Doctor (Name) _____

[] Atlanta Journal [] Internet [] Company Benefit Fair [] Direct Mail [] Unknown [] TV

[] Yellow Pages [] Insurance

[] Woodhams Patient Referral (Name) _____

[] Other _____

Have you or any of your blood relatives ever been told you have: (write "S" for Self, "R" for Relative)

Cataract ____ Glaucoma ____ High blood pressure ____ Diabetes ____ Macular Degeneration ____

Do you wear: Prescription glasses? [] All the time [] Sometimes [] Not really

Reading glasses? [] All the time for up close. [] Sometimes [] No

Contact Lenses? [] Yes. Hard or Soft [] No [] Occasionally

If you do wear contacts presently, what brand? _____

It would be helpful if you could tell us the Prescription RT: _____ LT: _____

Are you currently taking [] Accutane [] Cordalone [] Zomig [] Imitrex [] Flomax

If you are currently taking any of these drugs please advise us before you schedule surgery

List any allergies to medications _____

Any medical conditions you're being treated for? _____

Tell us the medications you are currently taking _____

Eye History

Circle "Yes" to indicate if you have any of the following:

Bloodshot Eyes	Yes	Floaters or Spots	Yes
Blurred Vision Distance	Yes	Glaucoma	Yes
Blurred Vision Near	Yes	Headaches	Yes
Burning Eyes	Yes	Itching Eyes	Yes
Cataracts	Yes	Light Sensitive	Yes
Color Vision Poor	Yes	Loss of Vision	Yes
Crossed Eyes	Yes	Migraine Headaches	Yes
Discharge from Eyes	Yes	Night Vision Poor	Yes
Dizzy Spells	Yes	Red Eyes	Yes
Double Vision	Yes	Seeing Halos	Yes
Dry Eyes	Yes	Seeing Flashes	Yes
Eye Infection	Yes	Temporary Loss of Vision	Yes
Eye Strain	Yes	Twitching Eyelid	Yes
Fainting Spells	Yes	Vision Poor	Yes
Blackouts	Yes	Watering Eyes	Yes
Eye Injury	Yes	Latex Allergy	Yes

Health History

Circle "Yes" if you have any of the following.

AIDS	HIV+	Yes	Hepatitis	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
Arthritis		Yes	High Blood Pressure	Yes
Artificial Heart Valve	Yes		Kidney Disease	Yes
Artificial Joints	Yes		Lazy Eye	Yes
Asthma	Yes		Lupus	Yes
Bleeding	Yes		Migraine Headaches	Yes
Blindness	Yes		Pacemaker	Yes
Cancer	Yes		Poor Color Vision	Yes
Cataracts	Yes		Retinal Disease	Yes
Chemical Dependency	Yes		Rheumatic Fever	Yes
Diabetes	Yes		Shingles	Yes
Drug Sensitivity	Yes		Skin Conditions	Yes
Emphysema	Yes		Stroke	Yes
Epilepsy	Yes		Thyroid Conditions	Yes
Eye Surgery	Yes		Tuberculosis	Yes
Heart Condition	Yes		Turned Eye	Yes
Hay Fever	Yes			
Are you Pregnant?	<input type="checkbox"/>	Breast Feeding?	<input type="checkbox"/>	
Tobacco Use	<input type="checkbox"/>			
Alcohol Use	<input type="checkbox"/>			

Have you ever passed out during a medical procedure, dental procedure, or giving blood? Yes No

Patient Name: _____

Date: _____

Except medical emergency, payment is required at the time of service. We will be happy to assist you with any insurance you may have. **Please indicate your form of payment today:**

Lasik Evaluation –I have never been evaluated at Woodhams Eye Clinic & I have never had previous eye surgery. I understand that this is a surgical evaluation and I will not receive a prescription for glasses or contacts.

Cash Personal check Visa-MasterCard-American Express-Discover

Signature X _____ Date _____

Insurance: List your primary insurance company first.

The Front Office will need copies of current insurance cards in order to process your insurance claim properly.

Name of Primary Carrier: _____

Name of Insured _____ Date of Birth _____ SS# _____

Policy # _____ Group# _____

Secondary: _____

Name of Insured _____ Date of Birth _____ SS# _____

Policy # _____ Group# _____

NOTICE- WE DO NOT ACCEPT GA MEDICAID

DO YOU HAVE VSP INSURANCE? : _____

In signing below, I authorize any medical or other information about me needed for proper processing of any claim to be released to Medicare or Commercial Insurance companies or to their intermediaries. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I understand that it is my responsibility to verify benefits and coverage for any services performed and that I will be personally responsible if my insurance does not pay within 60 days after the claim is submitted.

X _____ Date _____
Signature

Patient Name: _____

Date _____

Woodhams Eye Clinic
Woodhams Laser & Lens Implant Center

Patient Acknowledgement of Notice of Privacy Practices

As Required by the Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I have received a copy of the Notice of Privacy Practices of Woodhams Eye Clinic and Woodhams Laser & Lens Implant Center on the date indicated below.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the offices of Woodhams Eye Clinic and Woodhams Laser & Lens Implant Center.

I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future or if I have any questions with regard to this Notice of Privacy Practices, I may contact Woodhams Eye Clinic & Woodhams Laser and Lens Implant Center.

Patient Consent For Use And Disclosure Of Protected Health Information

I hereby give my consent for Woodhams Eye Clinic & Woodhams Laser and Lens Implant Center to use and disclose **protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO)**. Woodhams Eye Clinic & Woodhams Laser and Lens Implant Center's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Woodhams Eye Clinic & Woodhams Laser and Lens Implant Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Woodhams Eye Clinic
Woodhams Laser & Lens Implant Center
Attention: Compliance Officer
1140 Hammond Drive E-5100
Atlanta, GA 30328
770 394-4000
770 913-0841 FAX

With this consent, Woodhams Eye Clinic & Woodhams Laser and Lens Implant Center may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care.

With this consent, Woodhams Eye Clinic & Woodhams Laser and Lens Implant Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Woodhams Clinic & Woodhams Laser and Lens Implant Center may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

I have the right to request that Woodhams Eye Clinic & Woodhams Laser and Lens Implant Center restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Woodhams Eye Clinic & Woodhams Laser and Lens Implant Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Woodhams Eye Clinic & Woodhams Laser and Lens Implant Center may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

Date