Dr. Eric Randle
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Phone (662) 380-5041 Fax (662) 380-5042

PATIENT REGISTRATION

PATIENT INFORMATION: [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Miss [ ] Dr. Race/Ethnic Group: _____

[ ] Male [ ] Female [ ] Married [ ] Single [ ] Widowed Birthdate: _____/_____/_____Age: _____

Patient Name: _____
First Middle Last

Home Address: _____
No. & Street Apt. # City State Zip

E-mail: _____

Home Phone: _____ Other Phone: _____
Circle: Pager Cell Fax

Work Phone: _____ Ext. _____Employer: _____

Occupation: _____Social Security #:_____-_____-_____

How did you hear about us?

_____

Name of Medical Doctor: _____

Medical Address: _____
No. & Street Apt./Suite # City State Zip

Name of Any Other Eye Doctor: _____

Other Dr. Address: _____
No. & Street Apt./Suite # City State Zip

VERY IMPORTANT: Name & phone # of nearest relative(s) and/or friend to contact in case of emergency or appointment changes:

Name:_____ Phone: _____ Relation: _____

Name:_____ Phone: _____ Relation: _____

Responsible Party Information (If someone else other than yourself is responsible for payment):

Name & Date of Birth: _____
First Middle Last DOB

Home Address: _____
No. & Street Apt. # City State Zip

Social Security #: _____-_____- _____ Home Phone: _____

Employer: _____ Work Phone: _____

(PLEASE COMPLETE OTHER SIDE)

Medical and Vision Insurance Information: (Please provide us with information on ALL medical/health insurance coverages that you have. We also need to make a copy of your most recent insurance card(s) to keep on file.)

1) Insurance Company Name: _____Prior Authorization Required? [ ] Yes [ ] No

Address: _____ Phone: _____

ID or Policy #: _____Group #: _____Co-payment $ _____

Name & Date of Birth of Primary Insured (If other than yourself): _____

2) Insurance Company Name: _____Prior Authorization Required? [ ] Yes [ ] No

Address: _____ Phone: _____

ID or Policy #: _____Group #: _____Co-payment $ _____

Name & Date of Birth of Primary Insured (If other than yourself): _____

SIGNATURE ON FILE AUTHORIZATION

I request that payment of authorized Medicare or other insurance payment be made to the doctor on my behalf for any services provided to me by my physician. I authorize any holder of medical information about me to release to the Center For Medicare and Medicaid Services and its agent or any carrier all information needed to determine the benefits payable for related services. I further understand that I am responsible for the entire bill for medical services provided even though insurance has been filed on my behalf.

- **Insurance is filed as a courtesy to our patients.**
- **Balances are due within 30 days of filing date.**
- **Insurance co-payment and/or deductible and payment for non-covered services by insurance are due at the time of service.**
- **If for any reason this account is sent to collections, I understand that I will be responsible for all cost of collections including collection fees, court costs, and attorney fees.**

Signature of Patient or Responsible Party:_____Date: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

We will not share your information with anyone unless you list them and authorize us to do so.
Copies of our Privacy Practices are at reception desk.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name:_____ Date of Birth:_____

Signature: _____Date: _____

Who do you authorize us to release information to? _____

PATIENT INFORMATION AND MEDICAL HISTORY

1) Approximately how long has it been since your last eye exam? _____

2) Who did the exam? _____

3) How long have you had your present glasses? _____

4) Do you currently wear contacts? [ ] Yes [ ] No Current brand: _____

Please check all the following vision problems you are experiencing.

[ ] Blurred Vision, check all that apply

- [ ] Difficulty seeing distances
  - [ ] Watching television
  - [ ] Driving
    - [ ] Driving at night
    - [ ] Driving during the day
    - [ ] Seeing traffic signs
  - [ ] Recognizing people at a distance
  - [ ] Hunting
  - [ ] Other:_____

  _____

- [ ] Difficulty seeing near
  - [ ] Reading books, newspapers, etc.
  - [ ] Seeing computer
  - [ ] Sewing- threading a needle
  - [ ] Other: _____

  _____

[ ] Hazy/ Cloudy Vision
[ ] Seeing multiple images
[ ] Headaches
[ ] Eye Irritation, check all that apply
- [ ] Dryness
- [ ] Itching
- [ ] Redness
- [ ] Other: _____

_____

[ ] Eye Pain
[ ] Light Sensitivity, check all that apply
- [ ] Night Glare
- [ ] Seeing halos or streaks around lights
- [ ] Florescent light sensitivity
- [ ] Blue light (digital device) sensitivity
- [ ] Vision more blurred in sunshine

PAST MEDICAL HISTORY:

Are you currently being treated for or have you in the past had problems with any of the following? If so, please check all that apply.

[ ] Eye Disease
[ ] Neurological Disorders
[ ] Ear Nose Throat problems
[ ] Lung Disease
[ ] Heart Disease
[ ] Stomach Disease (GI)
[ ] Kidney Problems
[ ] Prostate Problems
[ ] Arthritis or Joint Disease
[ ] Psychiatric Disorders
[ ] High Blood Pressure
[ ] Diabetes Circle one: Type 1 Type 2
[ ] Skin Disease
[ ] Blood Disease
[ ] Thyroid Problems
[ ] Cancer

If yes, please explain: _____

_____

****PLEASE TURN OVER AND ANSWER QUESTIONS ON BACK****

SURGERIES:
List any eye surgery or other surgery you have had. _____

_____

MEDICATIONS:
Please list all medication you are taking and the dosage (milligrams). _____

_____

_____

ALLERGIES:
Are you allergic to any medication? [ ] Yes [ ] No
If so, what kind? _____

_____

FAMILY HISTORY:
Has anyone in your immediate family ever had any of the following? If so, list family member.

[ ] Glaucoma _____

[ ] Cataract _____

[ ] Blindness _____

[ ] Macular Degeneration _____

[ ] Other Eye Disease _____

[ ] Diabetes _____

[ ] Cancer _____

[ ] High Blood Pressure _____

[ ] Hyper/Hypo- Thyroid _____

List any other disease that runs in your family. _____

_____

SOCIAL HISTORY:
Do you smoke? [ ] Yes [ ] No
Did you ever smoke? [ ] Yes [ ] No
Do you consume more than one or two alcoholic beverages per day? [ ] Yes [ ] No
Do you live alone? [ ] Yes [ ] No