ALABAMA EYE SURGERY, P.C.
Patient Registration and Financial Agreement

Have you ever seen: Dr. Eich, Dr. Pearson or Dr. Luks? _____

PATIENT INFORMATION – PLEASE COMPLETE ENTIRE FORM

You must be 18 years old or older to complete and sign this form.

PATIENTS FULL NAME: DR., MISS, MRS. MR. _____ DATE_____

STREET ADDRESS_____ CITY_____ STATE____ ZIP CODE_____

AGE_____ SEX____ BIRTHDATE_____ HOME PHONE_____ CELL PHONE_____

SINGLE MARRIED WIDOWED DIVORCED SOCIAL SECURITY NO._____

PATIENT' S OCCUPATION_____ EMPLOYER (COMPANY)_____

EMPLOYER'S PHONE _____ REFERRED BY_____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

NAME_____ RELATIONSHIP_____

EMPLOYER (COMPANY)_____ PHONE_____

INSURANCE INFORMATION

BLUE CROSS-BLUE SHIELD OF ALABAMA_____ YES____ NO____

MEDICARE NUMBER_____ MEDICAID NUMBER_____

OTHER INSURANCE_____
COMPANY CONTRACT NO. GROUP NO.

MEDICARE: Most insurance companies do not pay for eye refractions. If I receive an eye refraction today I agree to pay for it. ($15.00)

ALL PATIENTS: I understand that the charges made by Alabama Eye Surgery for professional services may not be covered in full by any insurance covering such service to the patient. The patient and the party responsible for payment of fees for services rendered to the patient agree to make payment in full to Alabama Eye Surgery in such cases. The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney's fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama.

I understand that I am required to pay any health insurance deductibles, co-insurance co-payments or any other charges incurred which are not paid by insurance.

I authorize release of any medical information necessary to process an insurance claim.

CO-PAYMENT IS DUE AT TIME SERVICES ARE RENDERED.

SIGNATURE_____

ALABAMA EYE SURGERY, P.C.
801 PRINCETON AVENUE SW, SUITE 530
BIRMINGHAM, ALABAMA 35211
TELEPHONE 205-787-1411

PATIENT NAME_____ DATE_____

DATE OF BIRTH_____

PHYSICIAN OR STAFF OF DR. BRUCE S. EICH OR DR SUSAN B. LUKS HAS MY PERMISSON TO DISCUSS MY ACCOUNT AND MEDICAL CONDITIONS, WHICH MAY INCLUDE SYMPTOMS, TREATMENT, DIAGNOSIS, TEST RESULTS, MEDICATONS OR ANY OTHER TYPE OF PROTECTED HEALTH INFORMATON WITH THE FOLLOWING PERSONS IN ORDER TO FACILITATE AND COORDINATE MY CARE, TREATMENT AND PAYMENT.

NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER

I UNDERSTAND THAT AUTHORIZING THE RELEASE OF MY INFORMATION TO THE ABOVE INDIVIDUALS IS VOLUNTARY AND DOES NOT AFFECT MY ACCESS TO TREATMENT. I CAN REFUSE TO SIGN THIS FORM. I CAN REVOKE IT BY WRITING TO DR. BRUCE EICH OR DR. SUSAN LUKS OR COMPLETING A NEW FORM AT ANY TIME. THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL I CHANGE OR REVOKE IT. I UNDERSTAND THAT IF INFORMATION IS SHARED WITH THE ABOVE INDIVIDUALS IT MAY BE SUBJECT TO REDISCLOSURE BY THE INDIVIDUALS.

PATIENT SIGNATURE_____ DATE_____

ALABAMA EYE SURGERY, P.C .
NEW PATIENT QUESTIONNAIRE

Name:_____Birthdate_____Age_____

How did you find us (circle one): Referred by_____ flyer__ phone book _____
Advertisement (where:_____) Insurance directory_____Other: _____

MEDICAL REVIEW OF SYSTEMS: (explain all YES answers to these questions)

Constitutional Symptoms: recent high fever or unexplained weight loss:_____
Eyes: pain, blurred or double vision, redness, dryness, itching _____
cataract, glaucoma, lazy/crossed eyes, retinal disease, eye surgery, other _____
Ears, Nose, Mouth, Throat: deafness, sinus problems, surgery, other _____
Cardiovascular: heart attack/failure/murmur, high blood pressure, irregular heartbeat, other _____
Respiratory: asthma, emphysema. tuberculosis, cancer, other _____
Gastrointestinal: hepatitis, ulcers, hiatus hernia, cancer, other _____
Skin/Breast: skin disease/cancer, breast disease/cancer, other _____
Musculoskeletal: arthritis, lupus, cancer, surgery, other _____
Neurological: fainting, migraines, seizures/epilepsy, stroke, cancer, surgery, other _____
Psychiatric: depression, schizophrenia, other _____
Hematological: anemia, sickle cell, bleeding disorder, leukemia/lymphoma. Other _____
Endocrine: diabetes, thyroid disease, surgery, other _____
Allergic: seasonal allergies, immune problems, other _____

PAST FAMILY AND SOCIAL HISTORY
Describe any other health problems or surgeries not described above _____
Are you diabetic (if so, for how long) _____ Are you pregnant _____
List all current medications _____
_____
Are you allergic to any medications (if yes list all medications) _____
Describe any medical problems of family members _____
Do you drink alcohol or smoke _____

Date _____ Patient Signature _____

Date _____ Physician Signature _____