Today's Date:

PATIENT INFORMATION

Last Name	First	MI	Preferred Name	☐ Male ☐ Female	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Dr.
Street Address			City	State	Zip
Date of Birth	Social Security Number		☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Occupation	Employer		Cell Phone	Secondary Phone	
Email Address			How do you prefer to be contacted by our office? ☐ Text ☐ Email ☐ Phone call		

Referred by (please check one): ☐ Doctor_____ ☐ Insurance Plan ☐ Family ☐ Friend ☐ Billboard ☐ Close to home/work ☐ Google ☐ Other _____

Other family members seen here:

INSURANCE INFORMATION

Please give your insurance card to the receptionist

Person Responsible for Bill	Date of Birth	Address (if different)	Home Phone
Is this person a patient here? ☐ Yes ☐ No		Is this patient covered by insurance? ☐ Yes ☐ No	

Please indicate primary insurance: ☐ Medicare ☐ Blue Cross ☐ United Health Care ☐ Other: _____

Subscriber's Name:_____ Contract Number:_____ Subscriber's DOB: _____

Please indicate vision insurance: ☐ VSP ☐ VCP ☐ Other:_____

Subscriber's Name:_____ Subscriber's SSN:_____ Subscriber's DOB: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize R City Eye Care or my insurance company to release any information required to process my claims.

Patient/Guardian Signature:_____ Date: _____

Clarus Waiver

At R City Eye Care, we believe in using the most advanced technology to evaluate and manage conditions of the eyes. The Clarus is the latest ultra wide-field digital retinal imaging system, providing our doctors with 200 degree views of the retina in true color. This image will become a part of your permanent health record, enabling early detection of subtle changes from year to year. Clarus imaging is not the same as dilation, but, in most cases, the eyes will not need to be dilated during your routine examination if you have a Clarus image taken. If you have a medical eye condition that requires more advanced imaging, it will be required. The advanced imaging can be filed with your medical insurance, and you will not be charged for the screening image.

_____ Yes, I would like to have digital retinal screening performed. I understand that this is not covered by insurance and that there is an additional fee of $39.

_____ No, I would prefer to have my eyes dilated. I understand that my vision will be compromised and that I will have light sensitivity for 4-6 hours.

Signature of patient or personal representative:_____Date: _____

HIPAA Privacy Authorization

Authorization for Use or Disclosure of Protected Health Information, or PHI (Required by the Health Insurance Portability and Accountability Act {HIPAA}, 45 C.F.R. Parts 160 and 164)

1. Authorization
   I authorize R City Eye Care to use and disclose the protected health information described below to (individual seeing the information): _____
2. Effective Period
   This authorization for release of information covers the period of healthcare from:
   a. ☐ _____to_____ OR
   b. ☐ all past, present, and future periods
3. Extent of Authorization
   a. ☐ I authorize the release of my complete health record OR
   b. ☐ I authorize the release of my complete health record with the exception of the following information:
      - ☐ Mental Health Records
      - ☐ Communicable diseases (including HIV and AIDS)
      - ☐ Alcohol/drug abuse treatment
      - ☐ Other (please specify): _____
4. The person I authorize to receive this medical information may use it for medical treatment or consultation, billing or claims payment, or other purposes I may direct.
5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage, and the insurer has a legal right to contest a claim.
6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative_____Date: _____

Printed name of patient or personal representative_____Relationship:_____

**A copy of our full Privacy Policy is available at the front desk.*

Health History Form

Name:_____DOB:_____Pharmacy: _____

Date of last physical exam:_____Primary Care Physician: _____

Date of last eye exam:_____Previous Optometrist: _____

Medical History

Have you ever been diagnosed with:	Self	Relative	Relation
Diabetes	☐	☐	
High Blood Pressure	☐	☐	
High Cholesterol	☐	☐	
Thyroid Condition	☐	☐	
Heart Disease	☐	☐	
Heart Attack	☐	☐	
Stroke	☐	☐	
Arthritis	☐	☐	
Cancer	☐	☐	
Asthma	☐	☐	
Emphysema	☐	☐	
Allergies	☐	☐	
Kidney Disease	☐	☐	
Liver Disease	☐	☐	
Epilepsy/Seizures	☐	☐	
Migraines	☐	☐	
Multiple Sclerosis	☐	☐	
Blood Condition	☐	☐	
Autoimmune Condition	☐	☐	
Other (please list):	☐	☐	

I am adopted, and my family history is unknown. ☐

Have you ever been diagnosed with or exposed to: ☐ HIV/AIDS ☐ Hepatitis ☐ Other sexually-transmitted disease

Have you had herpes zoster/shingles? ☐ Yes ☐ No Are you currently pregnant and/or nursing? ☐ Yes ☐ No

Please list any major surgeries you have had: _____

Please list any medications you take, including over-the-counter medications: _____

Please list any allergies you have to medications, food, materials, dyes, etc.: _____

Ocular History

Have you ever been diagnosed with:	Self	Relative	Relation
Glaucoma	☐		☐
Cataracts	☐		☐
Macular Degeneration	☐		☐
Diabetic Retinopathy	☐		☐
Retinal Detachment	☐		☐
Retinal Disease	☐		☐
Amblyopia	☐		☐
Strabismus/Eye Turn	☐		☐
Dry Eye Syndrome	☐		☐
Keratoconus	☐		☐
Blindness	☐		☐
Other (please list):	☐		☐

Please list any eye drops you use, including over-the-counter: _____

Do you wear glasses? ☐ Yes ☐ No If so, do you wear them full-time or only sometimes? ☐ Full-time ☐ Sometimes Do you wear contact lenses? ☐ Yes ☐ No If so, what brand do you wear? _____

Are you wearing contacts today? ☐ Yes ☐ No How often do you replace your lenses? _____

Have you had LASIK, PRK, or any other refractive surgery? ☐ Yes ☐ No If so, when was your surgery? _____

Have you had cataract surgery? ☐ Yes ☐ No If so, when was your surgery? _____

Social History

Do you drive? ☐ Yes ☐ No Do you have visual difficulty while driving? ☐ Yes ☐ No If so, please explain: _____

Do you experience eye strain or fatigue at the end of the day? ☐ Yes ☐ No If so, how often? _____

How many hours per day do you work on a computer? _____ Do you have multiple monitors? ☐ Yes ☐ No

Do you participate in sports and/or hobbies that require eye protection? ☐ Yes ☐ No

Do you use tobacco products? ☐ Yes ☐ No If so, what type and how often? _____

Do you drink alcohol? ☐ Yes ☐ No If so, what type and how often? _____

Do you use illicit drugs? ☐ Yes ☐ No If so, what type and how often? _____

Review of Systems

Are you currently experiencing problems with any of the following (please circle):

Eyes: burning, itching, redness, dryness, watering, flashes of light, floaters Other: _____

Allergy: excessive itching, reaction to food, cream or medication Other: _____

Cardiovascular: chest pains or stiffness, heart murmur or palpitations Other: _____

Constitutional: fever, fatigue, weight loss, weight gain Other: _____

Endocrine: heat or cold intolerance, excessive thirst, excessive urination Other: _____

Gastrointestinal: loss of appetite, constipation, diarrhea, heartburn, nausea Other: _____

Genitourinary: urinary incontinence, frequent urinary infections Other: _____

Head: chronic cough, dry mouth, hearing loss, ringing in ears, frequent sinus infections Other: _____

Hematologic/Lymphatic: bleed or bruise easily, swollen lymph nodes, nose bleeds Other: _____

Immunologic: history of chicken pox, lyme disease, sarcoidosis, or tuberculosis Other: _____

Integumentary/Skin: changes to nails, eczema, hair loss, skin rashes or sores Other: _____

Musculoskeletal: back pain, joint pain or swelling, muscle pain or weakness Other: _____

Neurological: blackouts, memory loss, numbness, seizures, tingling, tremors Other: _____

Psychiatric: hallucinations, confusion, depression, mood swings, nervousness Other: _____

Respiratory: coughing, shortness of breath, wheezing Other: _____

RECORDS RELEASE

Patient Information:

Name: _____

Address: _____

_____ _____ _____
City State Zip

Phone: _____

Email: _____

Date of Birth: _____-_____-_____

I am requesting a copy of my eye care history with:

Doctor: _____

Address: _____

_____ _____ _____
City State Zip

Phone: _____ Fax: _____

to be forwarded to:

R City Eye Care
Dr. Rica McRoy & Dr. Alana Coker
4030 Balmoral Drive SW Ste A
Huntsville, AL 35801-6402
256-801-0099 256-533-1369 fax

R City Eye Care (Madison)
Dr. Melanie Cox & Dr. Marie Letson
8141 Madison Blvd Ste A
Madison, AL 35758
256-870-8141 256-870-8142

_____ _____
Signature Date