PREMIER MEDICAL EYE GROUP **DATE**
HISTORY FORM **CHART #**

PATIENT NAME_____ **DOB**_____/_____/_____ **AGE**_____

Preferred Pharmacy _____**Pharmacy Location**_____**Primary Care Physician**_____

TO HELP US MEET ALL YOUR HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETELY. THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE.

1. **PAST MEDICAL HISTORY** – Have you ever had the following: **__Patient denies any PMH**

_____Alzheimer's Disease	_____Diabetes Type 1	_____Hepatitis	_____Lupus	_____Sarcoidosis
_____Anemia	_____Diabetes Type 2	_____Herpes Zoster	_____Menieres	_____Seizures
_____Asthma	_____Fibromyalgia	_____High Cholesterol	_____Mental Health problems	_____Sickle Cell Anemia
_____Atrial Fibrilation	_____Gallbladder	_____Hypertension (HBP)	_____Migraines	_____Sinus
_____Bell's Palsy	_____Gastric Ulcer	_____Kidney Problems	_____Parkinson's	_____Sleep Apnea
_____Cancer	_____HIV	_____Liver Problems	_____Reflux	_____Stroke
_____Crohn's	_____Heart Disease	_____Lung Problems	_____Rheumatoid Arthritis	_____Thyroid problem
_____Depression				_____Tuberculosis

Other Including Eye Diseases:_____

2. **PAST SURGICAL HISTORY** – Have you ever had the following: **__ Patient denies any past surgeries**

_____Cancer Surgery	_____Hysterectomy	_____Thyroid Surgery
_____Gastric Bypass	_____Organ Transplant	_____Vascular Surgery
_____Heart Surgery	_____Sinus Surgery	_____Eye Surgery:

Other: _____

3. **CURRENT MEDICATIONS** (Please include dose and how many times per day taken.):

____Patient denies taking any medications

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all Medication Allergies

_____	_____	_____
_____	_____	_____

Allergic to: **__ Latex gloves**
__ Contrast dye/Iodine
__ No Known Drug Allergies

Turn Over and Complete Other Side

4. FAMILY HISTORY **____Patient denies family history**

_____Blindness	_____Diabetes Type 1	_____Hypertension	_____Retinal Detachment
_____Cataract	_____Diabetes Type 2	_____Keratoconus	
_____Cornea Transplant	_____Glaucoma	_____Macular Degeneration	

5. SOCIAL HISTORY:

Marital Status: □Single □Married Widowed Divorced □ Separated

Occupation: _____

***Tobacco:** ❑never ❑minimal ❑yes (___packs/day x ___ yrs) ❑quit ___yrs ago(___packs/day x ___ yrs)

6. REVIEW OF SYSTEMS:

DO YOU HAVE NOW OR HAVE YOU HAD ANY OF THE BELOW PROBLEM WITHIN THE PAST YEAR:
(Please circle anything for which you have a history of)

Constitutional:	fatigue	fever	weight loss
Eyes:	discharge from eye	eye pain	blurry vision
HENT:	headache	nasal congestion	sore throat
Cardiovascular:	chest pain		
Respiratory:	shortness of breath	hoarseness	wheezing
Gastrointestinal:	nausea	vomiting	reflux
Genitourinary:	possible pregnancy		
Integument:	rash	new skin lesions	
Neurological:	tingling or numbness	seizure	
Musculoskeletal:	joint pain		
Endocrine:	cold intolerance	heat intolerance	
Psychiatric:	anxiety	depression	
Blood-Lymph:	easy bleeding	easy bruising	
Allergic- Immunologic:	seasonal allergies		

PREMIER MEDICAL MANAGEMENT

ASSIGNMENT OF BENEFITS

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Premier Medical for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

_____

Print Name

_____ _____

Signature Date

Address_____

City, State, Zip_____

ACKNOWLEDGEMENT OF RESPONSIBILITY

I understand that I am financially responsible to you for all professional services rendered, including but not limited to those services which are not covered by my insurance (co-payments and/or deductibles). I also understand that if I have an HMO insurance and I do not obtain the proper referral prior to my visit that I am financially responsible for any charges incurred. I understand that payment for these charges is due at the time of service. I accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees (33-1/3%), attorney fees and/or court cost, if such be necessary. I understand I will be responsible for a "no show" fee if appointment not cancelled 24 hours prior to appointment time.

_____ _____

Signature Date

CONSENT TO CONTACT BY CELL PHONE

You agree, in order for us to remind you of appointments, service your account or to collect monies you may owe, Premier Medical and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

_____ _____

Signature Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS IS A SUMMARY OF THE FULL DISCLOSURE WHICH IS AVAILABLE UPON REQUEST. ***PLEASE REVIEW IT CAREFULLY.***

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; public health risks; and worker's compensation. Your signature of this Privacy Notice authorizes Premier Medical the use or disclosure of your PHI for marketing activities that are supported by third parties. I consent to Provider's use or disclosure of my PHI for purposes of delivering relevant product and/or technology marketing communication to me. I acknowledge that Provider may receive financial remuneration from the manufacturer in connection with such communications.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny *your* request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Practice. Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact James Hartman, Privacy Officer, 251-341-3368, 3701 Dauphin Street, Mobile AL 36608. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.** OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

Patient or Patient's Personal Representative _____ **Date** _____

Patient's Name (Please print) _____ **Medical Record #** _____

PERSONAL DATA SHEET

Date: _____

Account #: _____

Patient's Name: _____ Date of Birth: _____
Last First Middle

Mailing Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Primary Phone #:_____

Sex: ☐ M ☐ F Social Security #:_____ Marital Status: _____ Race: _____

Ethnicity: _____ Primary Language:_____ Preferred Pharmacy:_____

Employer: _____ Phone:_____

RESPONSIBLE PARTY (If not the same as patient)

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Social Security #: _____ Date of Birth: _____ Relationship to Patient: _____

Employer: _____ Phone: _____

Employer's Address: _____

SPOUSE INFORMATION

Name: _____ Social Security #: _____ Date of Birth: _____

Employer: _____ Phone: _____

Employer's Address: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Policy #: _____ Group #: _____

Insured: _____

Secondary Insurance Carrier: _____ Policy #: _____ Group #: _____

Insured: _____

Referring Physician: _____