JEFFRIES EYE ASSOCIATES
Compassion. Excellence. Respect.

MR#:_____
Office Use Only

PLEASE COMPLETE IN BLACK OR BLUE INK

DATE: _____

PATIENT INFORMATION

LAST **NAME:** _____ ***FIRST*** **NAME:** _____ **MIDDLE INITIAL:** _____

SOCIAL SECURITY #: _____ **BIRTHDATE:** _____ **SEX: M F**

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME PHONE #: _____

DAYTIME PHONE #: _____ **Is this a work #? Yes No *If yes, please list Employer below.**

CELL PHONE #: _____

DRIVER'S LICENSE #: _____**STATE:** _____

MARITAL STATUS: ☐ **MARRIED** ☐ **SINGLE** ☐ **WIDOWED** ☐ **SEPARATED** ☐ **DIVORCED**

SPOUSE'S NAME: _____ **PHONE #:** _____

RACE: ☐ **African-American** ☐ **Asian** ☐ **Caucasian** ☐ **Hispanic** ☐ **Other** _____

LANGUAGE SPOKEN: _____ **VETERAN:** ☐ Yes ☐ No

FAMILY DOCTOR (PCP): FIRST_____LAST_____**CITY:** _____

PHARMACY: _____**STREET:** _____**CITY:** _____

***EMPLOYER:** _____ **ADDRESS:** _____

WHO REFERRED YOU TO OUR OFFICE: _____

In Case of Emergency, please list a Family Member or Friend NOT LIVING WITH YOU:

NAME: _____ **RELATIONSHIP:** _____ **PHONE:** _____

STREET ADDRESS: _____ **CITY:** _____ **STATE & ZIP:** _____

- Please select your ***preferred*** contact number for **appointment call reminders.**

☐ **HOME #:** _____

☐ **CELL#:** _____ **This may include text messages.**

☐ **WORK#:** _____

- Our office utilizes a "Patient Portal", an online website patients can access their health information, appointments, medication requests and communicate via a secure email system with our practice. Please list your email address:

Email _____

INSURANCE INFORMATION - Please bring your insurance card(s) & photo ID to Appointment

Jeffries Eye Associates, P.A.
3602 Southern Hills Blvd
Rogers, AR 72758
479-631-8900

X_____
SIGNATURE OF PATIENT (Guardian or Parent Signature, if minor)

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Patient Financial Policy

Patient: _____ **Date:** _____

REFERRAL:

If your insurance plan requires a referral or pre-authorization, please contact your primary care physician or insurance and request that a referral be sent to our office. ***Failure to obtain a referral will require you to pay for the visit at the time of services***. Being seen without a referral or pre-authorization can result in reduced benefits or no payment by your insurance. If a referral is obtained after you visit, we will be happy to submit to your insurance and then reimburse you what the insurance company has paid. If you are uncertain whether your insurance requires a referral, please contact your insurance carrier.

PAYMENT:

Payment for your care is due at the time services are provided unless we have a contract with your health insurance plan. **Your co-pay and any deductible due are payable at the time of service.**

INSURANCE:

We require your current insurance identification card information. It is your responsibility to ensure the accuracy of information. We will file a claim for your services if Jeffries Eye Associates has a contract with your health insurance plan. However, if your insurance company fails to pay for your services, you may be responsible for any accrued charges. Any co-payment is due at the time services are rendered. If Jeffries Eye Associates does not have a contract with your insurance, payment is due in full the day of your visit..

INSURANCE AUTHORIZATION, ASSIGNMENT OF BENEFITS & CONSENT FOR EXAMINATION:

I hereby authorize Jeffries Eye Associates to give my insurance company, my attorney or my physician any and all information they may require concerning my case. I hereby assign to the clinic all payments for medical services, should it be desired to take such assignment. I understand that I am responsible for all charges regardless of insurance coverage. I further authorize the staff of Jeffries Eye Associates to examine my eyes and perform any services normally associated with an eye examination.

X _____
SIGNATURE OF PATIENT (Guardian or Parent Signature, if minor)

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Notice of Privacy & PHI

Patient: _____ **Date:** _____

PLEASE REVIEW THIS NOTICE CAREFULLY
As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

OUR COMMITMENT TO YOUR PRIVACY: Our practice is dedicated to maintaining the privacy of your individually identifiable health information [personal health information or PHI] as protected by law, including the Health Information Portability and Accountability Act (HIPAA).

In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI.

By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information:
How we may use and disclose your PHI
Your privacy rights in your PHI
Our obligations concerning the use and disclosure of your PHI
Your records may be electronically submitted to your insurance provider on your behalf for claims filing or other information as requested / needed by them.
The terms of this notice apply to all records containing your PHI that are created or retained.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM and ELECTRONIC RECORDS TRANSFER.

I have been offered a copy of the Jeffries Eye Associates' notice of privacy practices and give my permission for electronic records release for insurance, claims, and billing purposes on my behalf.

X_____
SIGNATURE OF PATIENT (Guardian or Parent Signature, if minor)

PERSONAL HEALTH INFORMATION RELEASE: Due to confidentiality laws, it is necessary for us to have written authorization to share your personal information with *friend or family member* should you become incapacitated or unable to deal with your business affairs for any reason**. Please list any individuals you would utilize in case of this event**.

I authorize Jeffries Eye Associates to release necessary medical and /or financial information about myself to:

_____ _____
(name) (relationship)

_____ _____
(name) (relationship)

_____ _____
(name) (relationship)

X_____
SIGNATURE OF PATIENT (Guardian or Parent Signature, if minor)

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Rogers, AR 72758
479-631-8900

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Medical Records Release Form

Patient: _____ **DOB:** _____ **Date:** _____

Please Sign At Bottom -

I Hereby Authorize: ***Leave blank - to be completed at office***
(Name & Address of releasing facility)

_____

_____

_____

To Release Information to:

Jeffries Eye Associates, P.A.

3602 Southern Hills Blvd

Rogers, AR 72758

PURPOSE OF DISCLOSURE:

( ) Continuing Care ( ) Legal ( ) For Personal Use
( ) School ( ) Worker's Compensation
( ) Other (Specify):_____

INFORMATION TO BE RELEASED: (Please check all that apply)

( ) Complete Medical Record ( ) Diagnostic test reports ( ) Exams
( ) Procedure Reports ( ) Other: _____

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand that the information in my medical records may include information relating to communicable disease(s), Acquired Immunodeficiency Syndrome ("AIDS"), or Human Immunodeficiency Virus ("HIV"), behavioral or mental health, alcohol/drug abuse or any such related information.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it well be effective on the date notified except to the extent action had already been taken.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand by authorizing this use disclosure of information, there will be no conditions placed on my health care or payment for my health care.

X _____
SIGNATURE OF PATIENT (Guardian or Parent Signature, if minor)

Jeffries Eye Associates, P.A.
3602 Southern Hills Blvd
Rogers, AR 72758
479-631-8900
479-899-6698 Fax

JEFFRIES EYE ASSOCIATES
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Allergies / Medications / Eye Health

MR#: _____
for office use

PLEASE COMPLETE IN BLACK OR BLUE INK

Patient: _____ Date: _____

DRUG ALLERGIES: ☐ Check if NONE

- ☐ Penicillin
- ☐ Codeine
- ☐ Sulfa
- ☐ Latex

_____
_____
_____
_____

MEDICATIONS: ☐ Check if NONE

- ☐ See attached listing of medications

OR, please list below

Mediction Name - Include Non-prescription (OTC)

EYE HEALTH: ☐ NONE

- ☐ Cataracts
- ☐ Corneal Disease
- ☐ Flashes of Light
- ☐ Floaters
- ☐ Glaucoma
- ☐ Lazy eye / Amblyopia
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Other: _____

EYE SURGERIES: ☐ NONE

		Year
☐ Cataract Surgery	RT	_____
	LT	_____
☐ Laser Surgery - *List Reason*		
	RT	_____
	LT	_____
☐ Retinal Surgery - *List Reason*		
	RT	_____
	LT	_____
☐ Refractive Surgery - *Circle Type*	RT	_____
LASIK RK PRK LRI	LT	_____

List any EYE INJURY/ TRAUMA:

_____
_____

SOCIAL HISTORY:

Do you smoke or use tobacco?	Yes	No
Former Smoker?	Yes	No
Cigarettes?	Yes	No
How many? pack _____ per	Day	Wk
Do you drink alcohol?	Yes	No
Do you drink caffeine?	Yes	No

X _____
SIGNATURE OF PATIENT (Guardian or Parent Signature, if minor)

Reviewed: _____

JEFFRIES EYE ASSOCIATES
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Health / Surgical / Family History

Patient: _____ Date: _____

HEALTH CONDITIONS ☐ NONE

Explain / Comments

- ☐ Allergies _____
- ☐ Angina _____
- ☐ Anxiety _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Atrial fibrillation _____
- ☐ Blood clots _____
- ☐ Cancer _____
- ☐ Cardiac arrythmia _____
- ☐ COPD _____
- ☐ Coronary artery disease _____
- ☐ Crohn's disease _____
- ☐ Depression _____
- ☐ Diabetes Type I x _____yrs
  Type II x _____yrs
- ☐ High Cholesterol _____
- ☐ Gallbladder disease _____
- ☐ GERD _____
- ☐ Headache _____
- ☐ Heart disease _____
- ☐ Heart valve disorder _____
- ☐ Hepatitis/liver disease _____
- ☐ HIV + or AIDS _____
- ☐ Hypertension _____
- ☐ Irritable bowel disease _____
- ☐ LUPUS _____
- ☐ Multiple Sclerosis _____
- ☐ Myocardial infarction _____
- ☐ Osteoporosis _____
- ☐ Renal disease _____
- ☐ Seizure disorder _____
- ☐ Sjogren's disease _____
- ☐ Stroke _____
- ☐ Thyroid disease _____
- ☐ Other: _____

SURGICAL: ☐ NONE

Year

- ☐ Angioplasty _____
- ☐ Arthroscopy Knee RT LT _____
  Shoulder RT LT _____
- ☐ Back surgery _____
- ☐ Blood transfusion _____

SURGICAL: ☐ NONE

Year

- ☐ CABG _____
- ☐ Cardiac pacemaker _____
- ☐ Cholecystectomy _____
- ☐ Colostomy _____
- ☐ Gastric bypass _____
- ☐ Hernia repair _____
- ☐ Hip replacement RT LT _____
- ☐ Hysterectomy _____
- ☐ Knee replacement RT LT _____
- ☐ Thyroidectomy _____
- ☐ Other:

FAMILY HISTORY: ☐ NONE

M=Mother, **F**=Father, **S**=Sister, **B**=Brother,
Son=Son, **D**=Daughter, **O**=Other

List How Related

- ☐ Amblyopia _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Blindness _____
- ☐ Cancer _____
- ☐ Cardiovascular disease _____
- ☐ Cataracts _____
- ☐ Corneal disease _____
- ☐ Diabetes _____
- ☐ Glaucoma _____
- ☐ High Cholesterol _____
- ☐ Hypertension _____
- ☐ Macular degeneration _____
- ☐ Migraines _____
- ☐ Multiple sclerosis _____
- ☐ Renal disease _____
- ☐ Retinal disease _____
- ☐ Seizure disorder _____
- ☐ Strabismus _____
- ☐ Stroke _____
- ☐ Thyroid disorder _____
- ☐ Other: _____

X _____

SIGNATURE OF PATIENT (Guardian or Parent Signature, if minor)

Reviewed: _____

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Review of Systems

MR#: _____
for office use

Patient: _____ Date: _____

Please check the appropriate boxes for current conditions.

CONSTITUTIONAL: ☐ NONE
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Loss
- ☐ Weight Gain

CARDIOVASCULAR: ☐ NONE
- ☐ Chest Pressure / Discomfort
- ☐ Irregular Heartbeat / Palpitation
- ☐ Leg Swelling

ENDOCRINE: ☐ NONE
- ☐ Cold Intolerance
- ☐ Heat Intolerance

INTEGUMENTARY: ☐ NONE
- ☐ Hives
- ☐ Rashes
- ☐ Skin Changes

ENT: ☐ NONE
- ☐ Hearing Loss
- ☐ Nasal Congestion
- ☐ Sinus
- ☐ Sore Throat
- ☐ Tinnitus (Ringing in Ear)
- ☐ Vertigo

GASTROINTESTINAL: ☐ NONE
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

NEUROLOGICAL: ☐ NONE
- ☐ Balance Disturbances
- ☐ Dizziness
- ☐ Focal Weakness
- ☐ Headache
- ☐ Numbness of Extremities

MUSCULOSKELETAL: ☐ NONE
- ☐ Arthralgias (Joint Pain)
- ☐ Back Pain
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Muscle Weakness

RESPIRATORY: ☐ NONE
- ☐ Asthma
- ☐ Cough
- ☐ Wheezing

GENITOURINARY: ☐ NONE
- ☐ Dysuria (Painful Urination)
- ☐ Urgency / Incontinence

PSYCHIATRIC: ☐ NONE
- ☐ Depressed Mood
- ☐ Emotional Changes
- ☐ Hallucinations

HEMATOLOGIC / LYMPHATIC: ☐ NONE
- ☐ Bleeding
- ☐ Bruising
- ☐ Tender Lymph Nodes

IMMUNOLOGIC: ☐ NONE
- ☐ Seasonal Allergies

Does Anyone In Your Family Have:

Diabetes? Yes No
If yes, who: _____

Glaucoma? Yes No
If yes, who: _____

Macular Degeneration? Yes No
If yes, who: _____

Surgeries / Hospitalizations / Illness in last year?

_____

X _____
SIGNATURE OF PATIENT (Guardian or Parent Signature, if minor)

Reviewed: _____