UAB EYE CARE
The University of Alabama at Birmingham

The Gift of Sight

Patient Application

Patient Information

					Date of Birth	Today's Date	
Patient Name (First, Middle, Last)	Suffix (Jr.,Sr.)	Salutation (Mr.,Ms.)	Social Security #	Birth State	Sex	Age	
Address (Home, Billing Address, Office/Business - circle)		City, State , Zip		Country United States			
Home Phone	Cell Phone	Work Phone / Ext	Email Address	Preferred Communication (Cell, Email)			
Special needs							
Primary Language	Marital Status	Maiden Name	Mother's Maiden Name				
Gender Identity (Male, Female, Male-to-female transsexual, Female-to-male transsexual)	Sexual Orientation (Straight, Bisexual, Homosexual, Other, Don't Know)						
Race	Race 2	Ethnicity	Ethnicity 2				
Employer	Occupation						

Responsible Party Information

Responsible Party's Name (Salutation, First, Middle, Last)	Date of Birth	Home Phone	Cell Phone	Work Phone / Ext	
Address (Street, City, State, ZIP)	Email Address	Social Security #	Gender		

Primary Insurance

Insured's Name	Date of Birth	ID Number
Insurance Company Name		Insurance Co. Phone
Insurance Company Address		
Group Name	Group Number	

Secondary Insurance

Insured's Name	Date of Birth	ID Number
Insurance Company Name		Insurance Co. Phone
Insurance Company Address		
Group Name	Group Number	

Monthly income $

Are you currently on food stamps?

Referrals - Shelters and Organizations only

Firm/Organization/Name	Phone	Address	Contact Person

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PATIENT HISTORY FORM

NAME: Birthdate: _____/_____/_____

Last First M. I.

Reason for today's clinic visit:

Please list any concerns you have about your eyes or vision:

Last Eye Exam: Dr. or location

Last Physical Exam: Dr. or location

CURRENT MEDICATIONS

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug **Dose (include strength & number of pills per day)**

1.
2.
3.
4.
5.
6.
7.
8.

Drug allergies: ❑ No ❑ Yes To what?

PAST MEDICAL HISTORY

Do you now or have you ever had:

❑ Diabetes
❑ High blood pressure
❑ High cholesterol
❑ Stroke
❑ Heart problems
❑ Cancer (type)_____
❑ Arthritis
❑ Thyroid problems
❑ Liver Problems
❑ Kidney Problems
❑ Cataracts
❑ Glaucoma
❑ Macular Degeneration
❑ Crossed Eyes/Strabismus
❑ Contact Lens Wear
❑ Eye Sx
❑ Eye Injury

Family Ocular Medical Hx:

❑ Diabetes
❑ Hypertension
❑ Stroke
❑ Heart

❑ Cataracts
❑ Glaucoma
❑ Macular Degeneration
❑ Strabismus

Any other patient/family general medical or ocular conditions (please list):

Do you drink alcohol? Yes ❑ No ❑	Do you use tobacco? Yes ❑ No ❑	Are you pregnant? Yes ❑ No ❑
Servings per week	If yes, how much?	Are you nursing? Yes ❑ No ❑

Do your hobbies or work put you at risk of an eye injury?

Do you have problems in the following areas?

General Health	Yes ❑ No ❑	Genital/Urinary	Yes ❑ No ❑	Blood or Lymphatic	Yes ❑ No ❑
Ears/Nose/Throat	Yes ❑ No ❑	Skin	Yes ❑ No ❑	Allergies/Immunology	Yes ❑ No ❑
Cardiovascular	Yes ❑ No ❑	Musculoskeletal	Yes ❑ No ❑	Endocrine	Yes ❑ No ❑
Respiratory	Yes ❑ No ❑	Neurological	Yes ❑ No ❑	Psychiatric	Yes ❑ No ❑
Gastrointestinal	Yes ❑ No ❑				

Attending (Initials):

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Internal Use Only: MRN _____

UAB Eye Care Exam Authorizations

SERVICES AND FEES: I hereby consent to the examination and treatment that the provider feels is necessary for rendering good vision care. I understand that some services I receive at UAB Eye Care may be provided by qualified optometric interns in training, under the direct supervision of a fully degreed and licensed optometrist or other physician who will repeat key parts of the examination. I understand that the services I receive will only be performed when felt necessary and that some of these services may not be covered by my insurance. I understand I will be responsible for payment in full for all such services not covered by my insurance, that they may be considered lawful debt and promise to pay said fees including the cost of collection **($50 collection fee will be assessed for any accounts sent to collections)**, attorney 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 or any other state.

THE USE OF DILATING DROPS: I understand than in order to completely examine the eye, the physician will often require the use of dilating drops to enlarge my pupils. I understand that dilation frequently causes sensitivity to light and may blur vision to a degree and for a length of time which varies from person to person (usually 2-4 hours), and that, as a result, may temporarily impair ability to drive or perform certain tasks. Other extremely rare adverse effects include angle-closure glaucoma.

I understand that dilation is generally recommended at least every 1-2 years, depending on age, risks and symptoms. I understand that a retinal photograph does not replace the need for a dilated eye exam. Risk factors include, but are not limited to:

- High myopia (-6 or greater Rx)
- History of retinal tear or detachment
- New onset flashing lights, floaters or partial loss of vision
- Recent history of trauma
- Medical conditions such as diabetes
- Any concerning pathology on fundus photos that requires further dilation.

PERMISSION TO FILE INSURANCE CLAIMS AND FOR DIRECT PAYMENT OF INSURANCE BENEFITS: I authorize UAB Eye Care to file claims to my insurance provider on my behalf. I understand that I can revoke this authorization at any time by providing UAB Eye Care with a written statement indicating that I revoke this authorization.

PERMISSION FOR DIRECT PAYMENT OF INSURANCE BENEFITS: I authorize my insurance provider to make payments on my behalf directly to UAB Eye Care. I understand I can revoke this authorization at any time by providing UAB Eye Care with a written statement indicating that I revoke this authorization.

PERMISSION TO RELEASE RECORDS TO OTHER HEALTHCARE PROVIDERS: I authorize UAB Eye Care to release records information regarding my care to other healthcare providers involved in my medical care. I understand I can revoke this authorization at any time by providing UAB Eye Care with a written statement indicating that I revoke this authorization.

PERMISSION TO USE ANONYMOUS MEDICAL INFORMATION IN HEALTHCARE TRAINING: I authorize UAB Eye Care to, when indicated, make use of information for my medical records (including images of medical conditions) for the purposes of medical education. I understand that information used in this manner will not identify me by name and that I can revoke this authorization at any time by providing UAB Eye Care with a written statement stating such.

NOTICE OF PRIVACY PRACTICES (HIPAA): I understand that UAB Eye Care and its affiliated clinics may share health information for treatment, billing, and healthcare operations. I acknowledge that I received notice of the UAB Eye Care Notice of Health Information Practices that describes how my health information is used and shared. I understand that UAB Eye Care and its affiliated clinics have the right to change this notice at any time. I may obtain a current copy by contacting UAB Eye Care or any of its affiliated clinics.

EYEGLASS/CONTACT LENS PRESCRIPTION DELIVERY: I would like my eyeglass and/or contact lens prescription sent to me electronically via my patient portal. Yes ☐ No ☐

By signing below, it constitutes my acknowledgement that I have read and agree with all of the above.

_____ _____ _____

Patient or Authorized Representative | Date of Birth | Date of Exam

UAB and UAB Medicine Enterprise

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT INFORMATION for UAB/UAB MEDICINE MARKETING AND COMMUNICATIONS

I hereby authorize the use or disclosure of my protected health information ("PHI") as described below. I understand that this authorization is voluntary. Once this information has been disclosed, it may be subject to re-disclosure and no longer be protected by federal privacy regulations.

Patient Name: _____ **Patient Birthdate:** _____/_____/_____

Patient Address: _____

Patient's Phone: (_____) _____ **City, State, Zip:** _____

This authorization is for the purpose of sharing your health care story in writing, in photos, and/or in a video recording including, but not limited to, past health care provided to you, your current health care encounters, your appreciation to your providers and the staff, and your interactions with your health care provider(s), to be used for activities in support of UAB/UAB Medicine Marketing and Communications. These activities could involve all types of electronic and non-electronic media including, but not limited to, letters, announcements, newsletters, presentations, posters, and videos. Additionally, this authorization gives permission to your UAB/UAB Medicine physicians or other health care providers to disclose your information relevant to your story.

You will personally disclose your story to UAB representatives who will prepare it for use by UAB/UAB Medicine Marketing and Communications for the purposes indicated above.

The patient or the patient's representative must read and initial the following statements:

Initial:_____ I understand that I have a right to revoke this Authorization at any time by notifying UAB Medicine's Chief Privacy Officer in writing. If I do, I understand that revocation will not affect the information that has already been released in response to this Authorization. The Chief Privacy Officer can be reached at 205-996-5051.

Initial:_____ I understand that UAB/UAB Medicine may not condition the provision of treatment, payment, and enrollment in a health plan or eligibility for benefits on signing this Authorization.

Initial: _____ I understand that I, and my heirs or next-of-kin, surrender all rights and privileges to all negatives, prints, audio recordings, and/or video recordings mentioned above, as well as all current and future rights to UAB/UAB Medicine for these marketing and communications purposes.

This Authorization will expire when UAB/UAB Medicine discontinues its use of my story.

Signature of patient or patient's representative: _____

Printed Name of patient: _____

Printed Name of patient's representative: _____

Relationship of representative to the patient: _____

Date: _____

For office use only:

- This form is to be used if specific health information will be received directly from a UAB/UAB Medicine physician, other health care provider, or staff. OR
- The individual providing the consent/authorization is someone other than the patient to whom the information belongs.