TAYLOR EYECARE
FAMILY OPTOMETRY

Date: _____

Name: _____ Age: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

Phone#: _____ Cell#: _____

Email: _____

SS# (for insurance): _____

Insurance Information

Vision Insurance: _____ Member ID#: _____

Policy Holder's Name/Birthday/SS#: _____

Medical Insurance: _____ Member ID#: _____

Policy Holder's Name/Birthday/SS#: _____

Vision History

When was your last eye exam? _____ Do

you currently wear glasses? □ Yes □ No

If so, what type of lenses do you wear?

□ Single Vision □ Bifocal □ Trifocal □ Progressive □ OTC Readers

Do you currently wear contacts? □ Yes □ No

If so, what brand? _____

315 Crossgates Blvd. Ste. G,
Brandon, MS 39042
Phone# (601) 706-4752 Fax# (601) 510-9394

Do you have trouble with any of the following?

□ Blurred distance vision	□ Blurred near vision	□ Blurred computer distance
□Double vision	□ Loss of vision	□ Headaches
□ Flashes of light	□ Floaters	□ Watery eyes
□ Burning	□ Dry eye	□ Redness
□ Itching	□ Other: _____	

Medical History

Sometimes different diseases can affect your vision. Please check any of the following that applies to you:

□ Arthritis	□ Diabetes	□ Heart Disease	□ High Blood Pressure
□ Stroke	□ Thyroid	□ High Cholesterol	□ Migraine Headaches
□ Cataracts	□ Glaucoma	□ Macular Degeneration	□ Other: _____

Have you ever had eye surgery? □ Yes □ No If yes, what and when? _____

List any medications you take: _____

_____

Are you allergic to any medications? _____

Name of Medical doctor? _____ Are you pregnant or nursing? _____

Is there a family history of any of the following?

□ Blindness □ Cataracts □ Glaucoma □Macular Degeneration

□ Diabetes □ Other: _____

Doctor's Signature: _____

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Retinal Photography

Retinal Photography can assist us in early detection of retinal problems (retinal detachment, holes, thinning, etc.), optic nerve disease, pre-cancerous lesions, macular degeneration, hypertensive retinopathy, and diabetic retinopathy. It makes an excellent reference point from which to make future comparisons.

This is an optional test, however, we strongly recommend it. The pictures are important for all ages and especially for patients with a history of high blood pressure, diabetes, retinal problems, headaches, floaters, flashing light streaks, or a strong prescription for glasses.

The fee is $20.00. This test is not covered by insurance.

Please check the appropriate box below and sign.

I do want the retinal photography

I do not want the retinal photography

Signed: _____ Date: _____

*** For some patients, the doctor may require this test because of exam findings. In this case, you are responsible for the $20.00 fee.

Payment Policy

Payment is expected at the time services are rendered. Glasses require payment in full prior to ordering unless arrangements have been made with management. Uncollected fees whether from insurance, insufficient funds, check stop payment, credit card charge backs, etc... remain the responsibility of the patient (Parent or legal guardian, if a minor). When insurance benefits are verified, the information provided by the customer service representative is **NOT** a guarantee of payment. There may be additional fees for co-pays, deductibles and non-covered services after payment is received from the insurance company.
A charge of $25.00 per patient will be charged for all missed appointments. To prevent this fee, you must contact our office at least 24 hour before your scheduled appointment time. This cancellation notice is expected and required.
By signing this statement, you agree to be financially responsible for any and all charges. In addition, you agree to pay all fees incurred to collect on your account if necessary.

Assignment of benefits (only applicable if we are filing with a vision or medical insurance for you). I hereby authorize my insurance/medical benefits to be paid directly to Taylor Eyecare & any associate of Dr. Anna Taylor. I further authorize release of any medical records or information necessary to process this claim.

Signature: _____ Date: _____

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Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information.

I have read and understand the information above. I also understand that Taylor Eyecare has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Taylor Eyecare at any time to obtain a current copy of the *Notice of Privacy Practices*.
_____**(Initial)**

I allow Taylor Eyecare to provide complete copies of medical records to any medical facility or person providing care to the patient _____ **(Initial)**

List any known individuals or medical facility you would like to have access to your medical records:

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____
Print Patient's name

_____ _____
Patient's/Guardian's Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship.

_____ _____
Print Guardian's/Representative's name Relationship to Patient

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