EYE ASSOCIATES OF THE SOUTH

1720A Medical Park Drive, #330
Biloxi, Ms. 39532
Phone: (228) 396-5185
Fax: (228) 396-5186
www.2020view.com

Ocean Springs
Phone: (228) 872-4444

Gulfport
Phone: (228) 575-4488

PATIENT INFORMATION
(Please Print)

Patient Name		**Social Security Number**	
Date of Birth	Age:	**Sex**	

Address:_____ **Apt #** _____
City:_____ **State:** _____ **Zip Code** _____
Home Phone: _____ **Cell Phone:** _____
Email: _____ **Martial Status**_____
Your *Primary Medical* Doctor_____ Referring Doctor_____
Person(s) we can discuss and or release your health information to: Self only ☐
Name(s)_____
Responsible Party (Name: Self, Spouse or Parent/Guardian)
Name:_____ SS# _____Date of Birth _____
Address _____ City _____ State _____ Zip _____
Place of Employment (Self or Parent) _____Phone #_____
Occupation (Patient) :_____
Place of Employment (Spouse)_____Phone #_____

Insurance Information:

Primary Insurance. _____**Policy #** _____
Group # _____ Relationship to Patient:_____
Insured Date of Birth:___/___/_____ SSN:_____
Vision Insurance _____ Policy # _____
Secondary Insurance Company: _____ **Policy#**_____
Group # _____ Insured Name on Card:_____
Insured Date of Birth:___/___/_____ Relationship to Patient:_____

The information that I have provided is true to the best of my knowledge. I authorize any insurance benefit to be paid directly to Eye Associates of the South, PLLC. I authorize the release of any medical information needed to process my insurance claims, As a courtesy to me, Eye Associates of the South may submit claims to my insurance carrier, if applicable. I understand I am financially responsible for any balance not paid by my insurance. I understand that if my account goes to an outside collections agency there is a $25.00 charge added to my balance. We understand that occasionally missed appointments occur for various reasons. A "No-show" is defined as missing an appointment without canceling at least 24 hours before the scheduled time. There will be a $25.00 charge for a missed or non-canceled appointment. Insurance will not cover these fees. I acknowledge that I have received a copy of Eye Associates of the South privacy notice. I understand that I am responsible to read this notice and notify Eye Associates of the South, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. Eye Associates of the South has the right to revise this notice at any time and will always post a copy of the current notice in the office in a visible location. Eye Associates will provide me with a copy of its most recent notice upon my request.

Signature **Date**

The electronic signature above and its related fields are treated by Eye Associates as a handwritten signature on a paper form.

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Name:_____ DOB _____

PAST MEDICAL HISTORY: (PLEASE CHECK ALL THAT APPLY OR "NONE" IF NONE APPLY)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke

Other_____
_____
_____

☐ **NONE**

PAST SURGICAL HISTORY: (PLEASE CHECK ALL THAT APPLY OR "NONE" IF NONE APPLY)

- ☐ Appendix Removed
- ☐ Breast Biopsy (Right, Left, Both)
- ☐ Lumpectomy (Right, Left, Both)
- ☐ Mastectomy (Right, Left, Both)
- ☐ Colectomy: Colon CA Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Heart: Coronary Artery Bypass
- ☐ Joint Replacement, Hip
- ☐ Joint Replacement, Knee
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Ovarian CA
- ☐ Ovaries Removed: Ovarian Cyst
- ☐ Prostate Removed: Prostate CA
- ☐ Prostate: TURP
- ☐ Skin: Basal Cell Cancer Surgery
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Uterus: Fibroids
- ☐ Uterus: Uterine Cancer
- ☐ Uterus: Cervical Cancer

Other_____
_____
_____

☐ **NONE**

OCULAR HISTORY: (PLEASE CHECK ALL THAT APPLY OR "NONE" IF NONE APPLY)

- ☐ Allergic Conjunctivitis
- ☐ Blepharitis
- ☐ Cataract (☐Left ☐Right)
- ☐ Corneal Dystrophy
- ☐ Diabetic Retinopathy
- ☐ Dry Eyes
- ☐ Glaucoma
- ☐
- ☐ LASIK (☐ Left ☐ Right)
- ☐ Macular degeneration (☐ Left ☐Right)
- ☐ Macular ERM (☐Left ☐ Right)
- ☐ Narrow angle (☐ Left ☐ Right)
- ☐ Ocular HTN (☐Left ☐ Right)
- ☐ Retinal tear (☐ Left ☐ Right)
- ☐ Strabismus
- ☐ PVD / Floaters (☐Left ☐ Right)

Other_____
_____
_____

☐ **NONE**

OCULAR SURGERY : (PLEASE CHECK ALL THAT APPLY OR "NONE" IF NONE APPLY)

- ☐ Cataract (☐Left ☐ Right)
- ☐ Glaucoma (☐Left ☐ Right)
- ☐ Retina tear(☐Left ☐ Right)
- ☐ Strabismus(☐ Left ☐ Right)
- ☐ Punctal Plugs
- ☐ Blepharoplasty
- ☐ LASIK (☐Left ☐ Right)
- ☐ Ptosis
- ☐ DCR
- ☐ YAG capsulotomy (☐Left ☐ Right)

Other_____
_____
_____

☐ **NONE**

PEDIATRIC HISTORY (FOR DR. EUSTIS PATIENTTS ONLY)

Gestational Age at birth	Weeks	**Birth Weight**	lbs oz
Maternal Illnesses during pregnancy		**Forcepts Delivery**	☐YES ☐NO

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Name:_____ **DOB:**_____

SOCIAL AND FAMILY (PLEASE CHECK ALL THAT APPLY OR "NONE" IF NONE APPLY

Social History
- ☐ Never smoked
- ☐ Smoker - Former
- ☐ Smoker - Current

Alcohol Consumption
- ☐ **None**
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ More than 3 drinks per day

Family History
- ☐ Diabetes
- ☐ Hypertension
- ☐ Glaucoma
- ☐ Cancer
- ☐ None

- ☐ Patient feels safe at home
- ☐ Patient feels unsafe at home

Preferred Pharmacy	City	State	Zip

Do you take any *pills*? Or **eye *drops or ointments*?** ☐ **NONE**

Name of Medicine	*Dose*	*For what condition*	How often

Do you have *ALLERGIES* to any medicines? ☐ **NONE**

Name of Medicine	Name of Medicine
1.	4.
2.	5.

Required by Federal Govt to inquire:

Have you received a Pneumonia Vaccination? ☐YES☐ NO Shingles Vaccination? ☐YES☐ NO
Do you have a Power of Attorney in the event you are unable to make your own medical decisions?
☐YES☐ NO
If so, Name: _____ Phone :_____
Do you have a living will? ☐YES☐ NO

Signature **Date**

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