Southern Eye Associates
Optical Medical Surgical / 864.269.3333 / Southern-Eye.com

Welcome Packet
New Patient

Hello,

We excited to welcome you to Southern Eye Associates. It is a pleasure having the opportunity to begin taking care of your eye health. Our practice and providers have had the opportunity to take care of patients for over 20 years of combined service. Each of our colleagues work jointly with other area practices to ensure that we create a network focused on your health overall.

Please complete the enclosed sections and give them to the receptionist when you arrive:

General Information
Contact Information
Insurance Information
Policy Holder Information
Emergency Contact Information
Referral Information
Primary Care Physician Information
Employment Information
Patient Contact Preferences
Medical Release Information
Past Medical History
Past Surgical History
Family History
Dry Eye Information
Tobacco Use
Medication Information
Allergy Information
Patient Portal Information
Acknowledgement of Privacy Practices and Patient Payment Policy
Advisory of Non-Covered Service
Contact Lens Information
Acknowledgement

Also bring with you the following items:

Eye glasses and/or contact lenses you currently use
Medical &/or Vision Plan Insurance cards (including primary policy holder information)
Photo identification
Form of Payment (Visa, Mastercard, Discover, American Express, Cash, & Checks)

We perform a comprehensive eye exam on all new patients to better understand your eyes health. This exam can take between 1 to 1 ½ hours to complete. If you have time restrictions, please let our front desk know during check in and we can work to accommodate your need. We will thoroughly examine your eyes and may order additional tests. In some cases, treatment may be initiated. If your pupils are dilated, it will cause temporary minor blurriness and light sensitivity that can last for several hours. Please exercise caution if you are driving and wear sunglasses or have someone transport you.

At the time of your exam, our front office team will collect any co-pays, co-insurance, deductibles, and non-covered services. Covered charges for our services will be billed directly to your insurance provider on your behalf. If you have both a Vision Care Plan and Medical Insurance, then please inform our team which type of coverage you wish to use. Typically Vision Care plans only cover routine exams plus eyeglasses and contact lenses. However, your Medical Insurance must be used if you have any eye or systemic health problem that requires care.

During your exam we will determine if these conditions apply to you, but some are determined by your case history. Southern Eye Associates accepts cash, check, credit cards and offers payment plans for higher balances. We look forward to serving you.

Thank you for your time,
Southern Eye Physicians

Patient Registration

General Information	
Name:	______________________ First Middle Last Suffix
Birthday:	_____/_____/_____
Current Age:	
Sex:	
SSN:	_______ - ____ - _______

Contact Information	
Address:	______________________ Street ______________ ________ ________ City State Zip Code
Phone:	(_____) _____ - _____ Mobile Phone (_____) _____ - _____ Home Phone (_____) _____ - _____ Work Phone
Email:	____________________ @ ______________ . _______

Insurance Information

Name of Medical Insurance & Card Number

Name of Secondary Medical Insurance & Card Number

Name of Vision Insurance & Card Number

Policy Holder Information

Name:	First ______ Middle ______ Last ______ Suffix
Birthday ____/____/____ Current Age:__________ Sex: __________	
Relationship:	
SSN:	______ - ____ - ______

Emergency Contact Information

Name:	______________________
Phone:	______ Relationship (____) ____ - ____ Mobile Phone (____) ____ - ____ Other Phone

Referral Information

Physician:	Dr. ______________________
Practice:	______________________
Reason:	______________________

Primary Care Physician Information

Physician:	Dr. ______________________
Practice:	______________________

Employment Information

Name:	______________________

Patient Contact Preferences

How would you prefer to be reminded about appointments?
O Email O Text O Phone Call

How would you like to be reminded about making follow up appointments?
O Email O Text O Phone Call

How would you prefer for our office to communicate with you?
O Email O Text O Phone Call

Medical Release Information

I authorize the following individuals to access my protected health information by contacting Southern Eye Associates.

Authorized Person:	First	Middle	Last	Suffix
Authorized Person:	First	Middle	Last	Suffix

By signing this form, I acknowledge receipt of the Notice of Provider Privacy Practices of Southern Eye Associates of SC, P.A., which outlines how they may use and disclose my protected health information. I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in the document by sending a written notification to Southern Eye Associates of SC, P.A I understand that their Notice of Provider Privacy Practices is subject to change and that I may obtain a copy of the revised notice or ask any questions by contacting Southern Eye Associates of SC, P.A. I hereby authorize Southern Eye Associates of SC, P.A to release my health information for purposes of treatment, payment and healthcare operations as described in Southern Eye Associates of SC, P.A Notice of Provider Privacy Practices.

Patient Portal Information

We are pleased to offer you the ability to review your medical records and communicate with our office via our secure patient portal. You will receive your secure login and password information at the end of your appointment at the checkout counter. This information is private and uniquely yours—please keep it in a safe place. Unfortunately, if you lose your secure password we are not permitted to give the information out over the phone.

Acknowledgement of Privacy Practices and Patient Payment Policy

I hereby authorize the providers at Southern Eye Associates to examine, diagnose and treat the above named patient for whom I am legally authorized to give consent including myself. By signing this form, I acknowledge receipt of the Notice of Provider Privacy Practices of Southern Eye Associates, which outlines how they may use and disclose my protected health information. I understand that a copy of the Notice of Provider Privacy Practices of Southern Eye Associates is also available at the check-in/reception desk. I understand that their Notice of Provider Privacy Practices is subject to change and that I may obtain a copy of the revised notice or ask any questions by contacting Southern Eye Associates at (864) 269-3333. I hereby authorize Southern Eye Associates to release my health information for purposes of treatment, payment (authorized to file Medicare and all other insurance plans) and healthcare operations as described in Southern Eye Associates' Notice of Provider Privacy Practices. I have read, understand and agree to the Patient Responsibility Payment Policy. I understand that any charges not covered by my insurance company are my responsibility, including costs associated with Refractions and Contact Lens Exams. I understand and authorize with my signature that my insurance benefits be paid directly to Southern Eye Associates, P.A.

You may request a copy of our Privacy Practices or Patient Payment Policy or read the displayed copies in our offices.

Advisory of Non-Covered Service

Please be advised that a refraction test will be performed as part of your eye exam at the cost of $40 if the service is not covered by your insurance. The payment for this service is requested prior or after your appointment. This is done to ensure we can accurately monitor your eye health and corrected best vision.

Past Medical History

Please check all that apply:

O Allergies
O Anemia
O Anxiety
O Arthritis
O Asthma
O Atrial fibrillation
O Benign Prostatic Hypertrophy
O Blood Clots
O Coronary artery disease
O Crohn's disease
O Breast Cancer
O Colon Cancer

O Ovarian Cancer

O ____________________
Other Cancer

O Depression
O GERD
O Heart attack
O Hepatitis C
O High blood pressure
O High cholesterol
O Insomnia
O Irritable bowel syndrome

O Kidney disease
O Migraines
O Osteoporosis/Osteopenia
O Seizures
O Sleep apnea
O Stroke
O Thyroid disease
O Ulcers
O Ulcerative colitis
O **None Apply**

O Diabetes   O Oral   O Insulin   O Diet-controlled   Year of Diagnosis:_________

Past Surgical History

Please check all that apply:

O Angioplasty
O Angio w/stents
O Back surgery
O Gallbladder surgery
O Heart bypass
O Joint replacement
O Knee surgery

O Pacemaker
O Thyroid surgery
O Cataract extraction
O Cornea transplant
O Shunt tube
O " Filter" Trabeculectomy
O LASIK

Glaucoma laser in:
O Right O Left
Laser of retinal tear in:
O Right O Left
Retina surgery in:
O Right O Left

Family History

Please check all that apply: O Adopted, Unknown Family History

	Mother	Father	Sister(s)	Brother(s)
Cataract	O	O	O	O
Glaucoma	O	O	O	O
"Lazy Eye"	O	O	O	O
Macular degeneration	O	O	O	O

Dry Eye Information

Have you ever been diagnosed with Dry Eye Disease or Ocular Surface Disease?
O Yes O No O When? ______________________________

Do you have any of the following symptomes?

O Redness
O Burning
O Light sensitivity
O Tired eyes, eye fatigue
O Foreign body sensation
O Fluctuating vision
O Scratchy feeling
O Itching
O Excess tearing / watering eyes
O Stringy mucus around the eyes
O Contact lens discomfort

Report the FREQUENCY of symptoms you are experiencing by using the numbering system below:

Symptoms	1	2	3
Dryness, Grittiness or Scratchiness	O	O	O
Soreness or Irritation	O	O	O
Burning or Watering	O	O	O
Eye Fatigue	O	O	O

Are your symptoms related to or made worse by any of the following factors?
O Windy conditions
O Places with low humidity (e.g., airplanes / hospitals)
O Areas that are air conditioned / heated
O More than 2 hours of computer / PDA use per day

Are you being treated for any of the following conditions?

O Diabetes
O Arthritis
O Sjögren's Syndrome
O Lupus
O Dry Eye
O Thyroid Condition
O Rosacea
O Blepharitis

Tobacco Use

Please check all that apply:

O Current everyday smoker
O Never Smoked
O Current some day smoker
O Former smoker
O Smoker, current status unknown
O Unknown if ever smoked

Medication Information

Please list all of the medication types and name of the medication you currently take:

Antibiotics

Allergy/Asthma/COPD

Autoimmune

Blood Pressure

Blood Thinners

Cholesterol

Depression/Bipolar/Alzheimer's

Diabetes

HIV

Pain

Allergy Information

Please check all that apply:

O No Known Allergies
O Latex
O Other ____________________
O Penicillin
O Non-steroidal
O Tetracycline
O Sulfa

Contact Lens Information

Please check all that apply:

O I am interested in Contact Lenses. (see information below)

O I am not interest in contact lenses.

If you are interested in contact lenses:

O Yes, I would like a copy of my vision plan benefits regarding contact lenses.

O No, I would not like a copy of my vision plan benefits regarding contact lenses.

Acknowledgement

I ____ (First and Last Name) have completed all 9 pages of the new patient packet. All information listed within the packet is accurate to the best of my ability and I would consider the information provided to be correct. I have read the welcome letter, completed the Patient Registration information including the sections labeled General Information, Contact Information, Insurance Information, Policy Holder Information, Emergency Contact Information, Referral Information, Primary Care Physician Information, Employment Information, Patient Contact Preferences, Medical Release Information, Past Medical History, Past Surgical History, Family History, Dry Eye Information, Tobacco Use, Medication Information, Allergy Information, Patient Portal Information, Acknowledgement of Privacy Practices and Patient Payment Policy, Advisory of Non-Covered Service, and Contacts Lens Information. I have read and understand all statements and agreements found within the new patient packet. By signing my name in the provided space as the patient listed or as the Legal Guardian of a minor under the age of 18 years of age I am expressing my consent and agreement to this agreement and statement. Upon signing the provided space and dating I understand and agree that all policies, requirements, acknowledgements, and agreements will take place from the date of signage forward.

Patient/ Legal Guardian:	First	Middle	Last	Suffix
Patient/ Legal Guardian:	Please sign the line above.			___/___/___ Date