Drs. Tidwell & Faulks
Optometry

Date _____

Contact Info:

Last Name: _____ **First Name:** _____ **MI** ____

Street Address _____ **City/State/Zip** _____

Telephone: Home ( ) _____ **Work: ( )** _____ **Cell: ( )** _____

E-Mail: _____

How do you prefer we contact you? ❑E-mail ❑Phone ❑Mail

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Personal Info:

Date of Birth ____/____/_____ **Gender: ❑ Male ❑ Female**

Social Security #: _____ - ____ - _____ **(for office use only)**

Employment Status: ❑Employed ❑Unemployed ❑Retired ❑Student ❑Active Military

If Employed, where? _____

Marital Status: ❑ Married ❑Single ❑Divorced ❑Widowed

Spouse Name (if applicable): _____

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Preferred Language: ❑English ❑Spanish ❑Other _____

Race: ❑White ❑African-American/Black ❑Asian ❑Native American ❑Hispanic
❑Middle Eastern ❑Pacific Islander ❑Native Hawaiian ❑Other _____

Ethnicity: ❑Hispanic/Latino ❑Non-Hispanic/Latino ❑Decline to Answer

****

Medical Information:

Please select any of the following medical conditions that you currently have:

__ Anxiety	__ Depression	__Hyperthyroidism
__Arthritis	__ Diabetes	__ Hypothyroidism
__ Asthma	__ End Stage Renal	__ Leukemia
__ Atrial Fibrillation	__ GERD	__ Lung Cancer
__ Bone Marrow Transplant	__ Hearing Loss	__ Lymphoma
__ Breast Cancer	__ Hepatitis	__ Prostate Cancer
__ Colon Cancer	__ Hypertension	__ Radiation Treatment
__ COPD	__ HIV/AIDS	__ Seizures
__ Coronary Artery Disease	__ High cholesterol	__ Stroke
__ Other _____		

Have you ever had surgery? ___ If yes, what type? _____

Please select any of the following eye conditions that *you* have been diagnosed with:

__ Cataracts	__ Dry Eyes	__ Macular Degeneration
__ Diabetic Retinopathy	__ Glaucoma	__ Retinal Detachment

Do you presently wear contact lenses? ❑No ❑Yes What type? _____

Do you have a *family history* of any of the following? If so, list family member:

❑Diabetes _____ **❑Macular Degeneration** _____
❑Glaucoma _____ **❑Retinal Detachment** _____
❑Hypertension _____ **❑Other** _____

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Do you currently take any medications? ❑No ❑Yes If so, please list below (or list separately):

_____

Do you have any allergies? ❑No ❑Yes If so, what?_____

Do you smoke? ❑Yes ❑No

Insurance information:

Vision Insurance:

Primary Vision Insurance _____

Member Name _____Member Date of Birth_____

Member ID/SSN_____Member's employer _____

Any secondary insurance? _____

Medical Insurance:

Primary Medical Insurance _____

Member Name _____ Member Date of Birth _____

Member ID/SSN _____ Member's employer _____

Any secondary insurance? _____

Patient relationship to member: ❑Self ❑Spouse ❑Child ❑Other

Parent/Guardian Info/Responsible Party for minor children:

Name_____

Address _____

City/State/Zip _____

Authorization to obtain Information and Benefit Payment:

I, the undersigned, certify that I (or my dependent) have insurance coverage listed above and assign directly to Drs. Tidwell and Faulks all insurance benefit payment for services rendered. I understand that I am financially responsible for all charges, whether assigned to insurance or not. I hereby authorize the doctor/staff to release all information necessary to secure payment of benefits. I authorized the use of this signature on all insurance submissions, whether submitted electronically or submitted on a standard paper CMS-1500 form.

_____ _____

Patient or Parent/Guardian signature Date

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HIPAA regulations require that we notify you of our privacy practices. We respect our legal obligation to keep health information that identifies you private. An extensive copy of our Notice of Privacy Practices is readily available in our office for any patient to obtain for personal inspection upon request. I have been notified of the privacy practices that are observed by Dr. Jerry Tidwell, Dr. David Faulks, Dr. Grant Allen, and all staff members.

Patient signature: _____ **Date:** _____