NEW PATIENT INFORMATION

PERSONAL INFORMATION (please print)

NAME: DATE:

DATE OF BIRTH: AGE: M/F: SOC SECURITY #:

RACE: ETHNICITY: PREFERRED LANGUAGE

ADDRESS:

PREF. PHONE: EMAIL:

OCCUPATION: EMPLOYER: EMP. PHONE:

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

IF INSURED BY SOMEONE OTHER THAN YOU

NAME OF PRIMARY HOLDER: HOLDER'S DATE OF BIRTH:

HOLDER'S SOC SECURITY #: HOLDER'S PHONE:

COMPLETE IF UNDER 18 YEARS OR A STUDENT

NAME OF FATHER: EMPLOYER:

ADDRESS:

PHONE: DATE OF BIRTH:

NAME OF MOTHER: EMPLOYER:

ADDRESS

PHONE: DATE OF BIRTH:

WHO TO NOTIFY IN CASE OF AN EMERGENCY (nearest relative or friend)?

NAME: RELATIONSHIP:

ADDRESS

HOME PHONE: WORK PHONE:

FINANCIAL ASSIGNMENT AND AGREEMENT

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.
2. In order to control your cost of billings, we request that your charges for office visits be paid at the conclusion of each visit unless you are covered by Medicare.
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf of any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNATURE (Patient or Parent if Minor) DATE

RUSSELLVILLE EYE CLINIC, P.A.
2711 East Parkway Drive
Russellville, AR 72811
Phone: (479) 968-7302
Fax: (479) 968-5131

Ophthalmology:
David S. Murphy, M.D.
John N. Gillespie, M.D.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM

I, _____ have received a copy of
(patient name)

Russellville Eye Clinic, P.A.'s Notice of Privacy Practices.

_____
Patient

_____
Date

Russellville Eye Clinic, P.A.

NAME: _____ **DATE:** _____

PLEASE CHECK ALL THAT APPLY

PAST MEDICAL HISTORY:

Anxiety ☐
Arthritis ☐
Asthma ☐
Atrial Fibrillation (Irregular Heartbeat) ☐
Bone Marrow Transplant ☐
BPH (Benign Prostatic Hyperplasia) ☐
Breast Cancer ☐
Colon Cancer ☐
COPD ☐
Coronary Artery Disease ☐
Depression ☐
Diabetes ☐
End Stage Renal Disease ☐
GERD ☐
Hearing Loss ☐
Hepatitis ☐
High Blood Pressure ☐
HIV/AIDS ☐
High Cholesterol ☐
Hyperthyroidism ☐
Hypothyroidism ☐
Leukemia ☐
Lung Cancer ☐
Lymphoma ☐
Prostate Cancer ☐
Radiation Treatment ☐
Seizures ☐
Stroke ☐

Other: _____

PLEASE CHECK ALL THAT APPLY

PAST SURGICAL HISTORY:

Appendix (appendectomy) ☐
Bladder Removal (cystectomy) ☐
Breast: Mastectomy (right) ☐
Mastectomy (left) ☐
Mastectomy (both) ☐
Breast: Lumpectomy (right) ☐
Lumpectomy (left) ☐
Lumpectomy (both) ☐
Breast: Biopsy ☐
Colon (colectomy): Colon Cancer Resection ☐
Colon (colectomy): Diverticulitis ☐
Colon Removal: (colostomy) ☐
Gallbladder Removal (Cholecystectomy) ☐
Heart: PTCA (Percutaneous Transluminal Coronary Angioplasty) ☐
Heart: Coronary Artery Bypass Surgery ☐
Heart: Mechanical Valve Replacement ☐
Heart: Biological Valve Replacement ☐
Heart: Heart Transplant ☐
Joint Replacement: Knee (right) ☐
Joint Replacement: Knee (left) ☐
Joint Replacement: Knee (both) ☐
Joint Replacement: Hip (right) ☐
Joint Replacement: Hip (left) ☐
Joint Replacement: Hip (both) ☐
Kidney: Nephrectomy ☐
Kidney: Kidney Stone Removal ☐
Kidney: Kidney Transplant ☐
Liver: Shunt ☐
Liver: Liver Transplant ☐
Liver: Hepatectomy ☐
Ovaries (oophorectomy): Endometriosis ☐
Ovaries (oophorectomy): Ovarian Cyst ☐
Ovaries: Tubal Ligation ☐
Pancreas: Pancreactomy ☐

PLEASE CHECK ALL THAT APPLY

PAST SURGICAL HISTORY:

Prostate: (Prostatectomy): Prostrate Cancer ☐
Prostate: (Prostatectomy): Turp (Transurethral Resection) ☐
Rectum: Low Anterior Resection ☐
Rectum: APR (Abdominoperineal Resection) ☐
Skin: Skin Biopsy ☐
Skin: Basal Cell Carcinoma ☐
Skin: Squamous Cell Carcinoma ☐
Skin: Melanoma ☐
Spleen: (splenectomy) ☐
Testicles (orchiectomy) ☐
Tonsillectomy ☐
Uterus (Hysterectomy): Fibroids ☐
Uterus (Hysterectomy): Uterine Cancer ☐
Uterus (Hysterectomy): Cervical Cancer ☐

Other: _____

PLEASE CHECK ALL THAT APPLY

OCULAR HISTORY:

Allergic Conjunctivitis ☐
Blepharitis ☐
Cataract (right eye) ☐
Cataract (left eye) ☐
Contact Lens ☐
Corneal Dystrophy (right eye) ☐
Corneal Dystrophy (left eye) ☐
Diabetic Retinopathy, Background (right eye) ☐
Diabetic Retinopathy, Background (left eye) ☐
Diabetic Retinopathy, Proliferative (right eye) ☐
Diabetic Retinopathy, Proliferative (left eye) ☐
Dry Eyes ☐
Glasses ☐
Glaucoma ☐
Macular Degeneration ☐
Macular ERM (Epiretinal Membrane) ☐
Narrow Angles ☐
Ocular Hypertension ☐
Ophthalmic Migration ☐
Pseudoexfoliation ☐
Retinal Tear (right) ☐
Retinal Tear (left) ☐
Strabismus ☐
PVD (Posterior Vitreous Detachment) (right) ☐
PVD (Posterior Vitreous Detachment) (left) ☐
Vitreous Floaters (right) ☐
Vitreous Floaters (left) ☐

Other: _____

PLEASE CHECK ALL THAT APPLY

OCULAR SURGERY:

Blepharoplasty (right) ☐
Blepharoplasty (left) ☐
Cataract Surgery (right) ☐
Cataract Surgery (left) ☐
Corneal Transplant (right) ☐
Corneal Transplant (left) ☐
Eye Muscle Surgery ☐
Intravitreal Injections (right) ☐
Intravitreal Injections (left) ☐
Lasik (right) ☐
Lasik (left) ☐
Punctal Plugs (right) ☐
Punctal Plugs (left) ☐
Strabismus Surgery ☐
Retinal Laser (right) ☐
Retinal Laser (left) ☐
YAG Capsulotomy (right) ☐
YAG Capsulotomy (left) ☐

Other: _____

Please list any medications you are currently taking including over the counter meds, vitamins, minerals, eye drops and ointments:

Please list any allergies to medications below:

Have you smoked in the past? Yes ☐ No ☐
If yes, how many years total? _____
Do you smoke currently? Yes ☐ No ☐
If yes, how many years total? _____
Are you currently pregnant? Yes ☐ No ☐
Family History:

Blindness Yes ☐ No ☐
Cataracts Yes ☐ No ☐
Crossed Eyes Yes ☐ No ☐
Glaucoma Yes ☐ No ☐
Macular Degeneration Yes ☐ No ☐
Retinal Detachment Yes ☐ No ☐
Kidney Disease Yes ☐ No ☐

Lupus Yes ☐ No ☐
Cancer Yes ☐ No ☐
Diabetes Yes ☐ No ☐
Heart Disease Yes ☐ No ☐
High Blood Pressure Yes ☐ No ☐
Thyroid Disease Yes ☐ No ☐

Other: _____

Preferred Pharmacy:

_____

Primary Care Physician:

_____