UAB EYE CARE

The University of Alabama at Birmingham

Extension

ALABAMA A&M & AUBURN UNIVERSITIES

UAB Community Eye Care will provide

EYE EXAMS and **GLASSES**

to qualified individuals in your community.

Saturday, November 18th

9:00 Am – 2:00 PM

Autauga County Extension
2226 Hwy 14 W.
Autaugaville, AL 36003

CALL FOR APPOINTMENTS TIMES!!!

334-361-7273

DO YOU QUALIFY FOR THE PROGRAM?

- NO Vision or Medical Insurance is Required
- INCOME FALLS WITHIN POVERTY GUIDELINES
- CURRENTLY on FOOD STAMPS

ITEMS TO BRING TO YOUR APPOINTMENT

- Picture I.D.
- If RECIPIENT has NO MEANS OF INCOME, bring ONE of the following
  - Current Food Stamp Letter
  - Notarized Letter from Responsible Party
- If currently insured, bring insurance card

Everyone is welcome! Please let us know if you have accessibility needs.

www.aces.edu

UAB Eye Care

PATIENT:

AUTHORIZATIONS - PLEASE READ CAREFULLY

SERVICES AND FEES: I hereby consent to the examination and treatment that the provider feels is necessary for rendering good vision care. I understand that some services I receive at UAB Eye Care may be provided by qualified optometric interns in training, under the direct supervision of a fully degreed and licensed optometrist or other physician who will repeat key parts of the examination. I understand that the services I receive will only be performed when felt necessary and that some of these services may not be covered by my insurance. I understand I will be responsible for payment in full for all such services not covered by my insurance, that they may be considered lawful debt and promise to pay said fees including the cost of collection, attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama or any other state.

PERMISSION TO FILE INSURANCE CLAIMS AND FOR DIRECT PAYMENT OF INSURANCE BENEFITS: I authorize UAB Eye Care to file claims to my insurance provider on my behalf. I understand I can revoke this authorization at any time by providing UAB Eye Care with a written statement indicating that I revoke this authorization.

PERMISSION FOR DIRECT PAYMENT OF INSURANCE BENEFITS: I authorize my insurance provider to make payments on my behalf directly to UAB Eye Care. I understand I can revoke this authorization at any time by providing UAB Eye Care with a written statement indicating that I revoke this authorization.

PERMISSION TO RELEASE RECORDS TO OTHER HEALTHCARE PROVIDERS: I authorize UAB Eye Care to release records information regarding my care to other healthcare providers involved in my medical care. I understand I can revoke this authorization at any time by providing UAB Eye Care with a written statement indicating that I revoke this authorization.

PERMISSION TO USE ANONYMOUS MEDICAL INFORMATION IN HEALTHCARE TRAINING: I authorize UAB Eye Care to, when indicated, to make use of information from my medical records (including images of medical conditions) for the purposes of medical education. I understand that information used in this manner will not identify me by name and that I can revoke this authorization at any time by providing UAB Eye Care with a written statement stating such.

NOTICE OF PRIVACY PRACTICES (HIPAA): I understand that UAB School of Optometry and its affiliated clinics may share my health information for treatment, billing, and healthcare operations. I acknowledge that I have been given a copy of the UAB Eye Care Notice of Health Information Practices that describes how my health information is used and shared. I understand that UAB School of Optometry and its affiliated clinics have the right to change this notice at any time. I may obtain a current copy by contacting the UAB School of Optometry or any of its affiliated clinics.

My signature below constitutes my acknowledgment that I have been provided with a copy of the Notice of Health Information Practices.

_____

Signature of Patient (or Legal Representative) Date

If signed by legal representative, relationship to patient: _____

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PATIENT HISTORY FORM

NAME: Birthdate: _____/_____/_____

Last First M. I.

Reason for today's clinic visit:

Please list any concerns you have about your eyes or vision:

Last Eye Exam: Dr. or location

Last Physical Exam: Dr. or location

CURRENT MEDICATIONS

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	Dose (include strength & number of pills per day)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Drug allergies: ❑ No ❑ Yes To what?

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Stroke
- ❑ Heart problems
- ❑ Cancer (type)_____
- ❑ Arthritis
- ❑ Thyroid problems
- ❑ Liver Problems
- ❑ Kidney Problems
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Crossed Eyes/Strabismus
- ❑ Contact Lens Wear
- ❑ Eye Sx
- ❑ Eye Injury

Family Ocular Medical Hx:

- ❑ Diabetes
- ❑ Hypertension
- ❑ Stroke
- ❑ Heart
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Strabismus

Any other patient/family general medical or ocular conditions (please list):

Do you drink alcohol? Yes ❑ No ❑	Do you use tobacco? Yes ❑ No ❑	Are you pregnant? Yes ❑ No ❑
Servings per week	If yes, how much?	Are you nursing? Yes ❑ No ❑

Do your hobbies or work put you at risk of an eye injury?

Do you have problems in the following areas?

General Health	Yes ❑ No ❑	Genital/Urinary	Yes ❑ No ❑	Blood or Lymphatic	Yes ❑ No ❑
Ears/Nose/Throat	Yes ❑ No ❑	Skin	Yes ❑ No ❑	Allergies/Immunology	Yes ❑ No ❑
Cardiovascular	Yes ❑ No ❑	Musculoskeletal	Yes ❑ No ❑	Endocrine	Yes ❑ No ❑
Respiratory	Yes ❑ No ❑	Neurological	Yes ❑ No ❑	Psychiatric	Yes ❑ No ❑
Gastrointestinal	Yes ❑ No ❑				

Attending (Initials):

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Patient Application

Patient Information

				Date of Birth	Today's Date		
Patient Name (First, Middle, Last)	Suffix (Jr.,Sr.)	Salutation (Mr.,Ms.)	Social Security #	Birth State	Sex	Age	
Address (Home, Billing Address, Office/Business - circle)		City, State , Zip		Country United States			
Home Phone	Cell Phone	Work Phone / Ext	Email Address	Preferred Communication (Cell, Email)			
Special needs							
Primary Language	Marital Status	Maiden Name		Mother's Maiden Name			
Gender Identity (Male, Female, Male-to-female transsexual, Female-to-male transsexual)		Sexual Orientation (Straight, Bisexual, Homosexual, Other, Don't Know)					
Race	Race 2	Ethnicity	Ethnicity 2				
Employer	Occupation						

Responsible Party Information

Responsible Party's Name (Salutation, First, Middle, Last)	Date of Birth	Home Phone	Cell Phone	Work Phone / Ext
Address (Street, City, State, ZIP)	Email Address	Social Security #	Gender	

Primary Insurance

Insured's Name	Date of Birth	ID Number
Insurance Company Name		Insurance Co. Phone
Insurance Company Address		
Group Name	Group Number	

Secondary Insurance

Insured's Name	Date of Birth	ID Number
Insurance Company Name		Insurance Co. Phone
Insurance Company Address		
Group Name	Group Number	

Monthly income $

Are you currently on food stamps?

Referrals - Shelters and Organizations only

Firm/Organization/Name	Phone	Address	Contact Person