PATIENT DEMOGRAPHICS

Please read and answer all questions that apply.

LAST NAME: _____ **FIRST NAME:** _____ **MIDDLE INITIAL:** _____

MAILING ADDRESS: _____ **CITY:** _____ **ZIP:** _____ **STATE:** ____

STREET ADDRESS: _____ **CITY:** _____ **ZIP:** _____ **STATE:** ____

DATE OF BIRTH: _____ **AGE:** _____ **SS#:** _____ **MALE/FEMALE:** _____

HOME PHONE: _____ **CELL PHONE:** _____

PHARMACY INFORMATION:

PHARMACY NAME: _____

PHARMACY PHONE NUMBER: _____

MARITAL STATUS: SINGLE/ MARRIED/ DIVORCED/ WIDOWED/ OTHER

PATIENTS EMPLOYER: _____ **WORK PHONE:** _____

SPOUSE/PARENT NAME: _____ **SPOUSE'S PHONE NUMBER:** _____

EMERGENCY CONTACT: _____ **PHONE:** _____

BY GIVING YOUR EMAIL ADDRESS, YOU ARE GIVING PERMISSION FOR US TO SEND YOU AN INVITATION TO JOIN OUR PATIENT PORTAL WEBSITE. YOU WILL BE ABLE TO ACCESS YOUR RECORDS AND APPOINTMENTS. PLEASE ONLY GIVE US THE PATIENT'S EMAIL ADDRESS.

EMAIL ADRESS: _____

I have been given the opportunity to read and/or receive the privacy notice of Rayner Eye Clinic, LLC.

SIGNED: _____ **DATE:** _____

Rayner
EYE CLINIC

PATIENT INFORMATION AND MEDICAL HISTORY

Name _____ DOB_____ Date_____

1. I am here today because (please mark all that apply):
   A) A doctor at this or another clinic told me I have: ☐Cataracts ☐Glaucoma ☐Diabetes ☐Macular Degeneration ☐Retinal Problem ☐Dry Eyes ☐Cornea Problem

   B) I need a checkup for: ☐Cataracts ☐Glaucoma ☐Diabetes ☐Macular Degeneration ☐Decreased Vision ☐Dry Eyes ☐Previous Surgery ☐Retinal Problem

   C) I am experiencing problems related to: ☐Eye Pain ☐Decreased Vision ☐Dry Eyes ☐Itchy/Scratchy Eyes ☐Matted Eyes in Morning ☐an Eye Injury - Work related? YES NO ☐Flashing Lights ☐Floaters ☐Tearing/Redness ☐Other _____

   D) ☐I would like a Routine Eye Exam or Contact Exam
   ****PLEASE NOTE, IF YOU CHECK THIS BOX AND YOU HAVE MEDICARE, YOU WILL BE EXPECTED TO PAY IN FULL FOR TODAY'S VISIT.**

2. Approximately how long has it been since your last eye exam? _____
3. Who did that exam? _____
4. How long have you had your present glasses? _____
5. Do you currently wear contacts: YES NO

Please check the following vision problems you are experiencing.

_____ Hazy vision
_____ Blurry vision
_____ Difficulty reading newspapers
_____ Difficulty reading labels or price tags
_____ Difficulty reading a telephone book
_____ Difficulty sewing-threading a needle
_____ Do you use a magnifying glass to read?
_____ Difficulty seeing steps
_____ Difficulty seeing at a distance
_____ Difficulty watching television
_____ Vision more blurred in sunshine
_____ Difficulty driving in daytime
_____ Difficulty driving at night
_____ Difficulty seeing traffic signs
_____ Difficulty seeing traffic lights
_____ Difficulty recognizing people at a distance
_____ Difficulty seeing to hunt
_____ Difficulty doing a job or hobby because of blurred vision
_____ Seeing halos or streaks around lights
_____ Seeing multiple images

for office staff use only

I have reviewed with patient
HPI _____
PMH _____
PSH _____
Meds _____
FHx _____

Date _____
Initials _____

*** PLEASE TURN OVER AND ANSWER QUESTIONS ON BACK ***

Name _____ Date _____

Past Medical History:

Are you currently being treated for or have you in the past had problems with any of the following? If so, please check.

_____ Eye Disease
_____ Headaches or Neurological disorders
_____ Ear Nose Throat problem
_____ Lung Disease
_____ Heart Disease
_____ Stomach Disease (GI)
_____ Kidney Problems
_____ Prostate Problems
_____ Arthritis or joint disease
_____ Nervous (Psychiatric) disorders
_____ High Blood Pressure
_____ Diabetes
_____ Skin Diseases
_____ Blood Disease
_____ Fever or Weight Loss
_____ Thyroid Problems

If yes, please explain _____

_____

Surgeries:

List any Eye surgery OR OTHER SURGERY you have had. _____

_____

Medications:

Please list all medications you are taking. _____

_____

Allergies:

Are you allergic to any medications? _____ yes _____ no

If so what kind _____

_____

Family History:

Has anyone in your family ever had any of the following?

glaucoma _____ cataract _____ blindness _____ other eye disease _____

diabetes _____

List any disease that runs in your family _____

_____

Social History:

Do you smoke? _____ Did you ever smoke? _____

Do you consume more than one or two alcoholic beverages per day?

_____ yes _____ no

Do you live alone? _____ yes _____ no

COVID-19 PANDEMIC PATIENT DISCLOSURES

WE ASK THAT ALL PATIENTS & STAFF ANSWER THIS QUESTIONAIRE UPON ENTERING THE BUILDING.

IF YOU HAVE HAD SOMEONE ENTER THE BUILDING WITH YOU, THEY WILL ALSO NEED TO FILL OUT THIS QUESTIONAIRE.

THANK YOU FOR UNDERSTANDING.

Please read carefully and answer truthfully below

Please check below:	**Circle one**	**Circle One**
Have you been tested for COVID-19?	YES	NO
If you have been tested for COVID-19, what was your result?	NEGATIVE	POSITIVE
IF YOU HAD A POSITIVE COVID-19 RESULT, WHEN WAS IT?		
Do you currently have a fever or above normal temperature?	YES	NO
Have you been in contact with someone who has tested positive for COVID-19 recently?	YES	NO
Are you experiencing a cough that is out of the ordinary for you?	YES	NO
Have you experienced shortness of breath or had trouble breathing?	YES	NO
Have you recently lost or had a reduction in your sense of smell or taste?	YES	NO
Do you have a sore throat?	YES	NO

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Name **Date**

Rayner
EYE CLINIC

INFORMATION RELEASE AUTHORIZATION

I hereby authorize the person(s)/entities listed below to access, discuss and/or review my medical records at Rayner Eye Clinic, LLC without further authorization. Authorized persons will have complete access to my medical records including financial records. By signing below you are permitting Rayner Eye Clinic, LLC doctors and staff to discuss your medical history & financial history with such authorized persons. Any exceptions to this broad authorization should be noted beside each authorized persons name below. You may add or delete individuals on this list at any time with written notice or in person.

Authorized Individual/Entity	Exceptions	Date

PRINT Patient Name

Account #

Patients Signature

Date Signed

RAYNER EYE CLINIC, LLC

1308 Belk Drive • Oxford, MS 38655
(662) 234-6551 • 1-800-237-3430

6762 Getwell Road • Southaven, MS 38672
(662) 890-1112

Dear Patient:

We appreciate your choosing Rayner Eye Clinic to take care of your eye care needs. Our doctors and staff will do everything in their power to make this as pleasant an experience as possible. We are committed to your eye care needs. If you have questions, please ask our staff and someone will assist you. Our policies are as follows:

OFFICE HOURS: Our office hours are 7:30 a.m. to 5:00 p.m. Monday through Thursday and on Friday from 7:30 a.m. to 4:00 p.m. Any emergencies are handled through our answering service, which will page the doctor on call. You can reach our office 234-6551 or the answering service 24 hours a day, 7 days a week. Please also use this number to cancel an appointment if you cannot come in. We would appreciate a 24 hour notice of a cancellation.

RELEASE OF MEDICAL RECORDS: In order to protect your privacy, we require an authorized signature from you to release records to anyone. If an attorney is involved, the attorney will need to obtain a notarized signature and the attorney's office will need to request the release of your medical records.

INSURANCE: If you have insurance coverage, please know that your coverage is an agreement between you and your insurance company. We do our part to take care of your medical needs, but you are responsible for your insurance company doing their part. Insurance is frustrating and sometimes very hard to understand. We, however, cannot know about all the individual policies available and what yours does or does not pay. In essence, you are responsible for your bill. We will give the insurance company 60 days to respond and we will bill them the second time, but after that it will be between you and your company.

If you have insurance which requires you to have a referral from another physician, that is your responsibility. If you do not have a referral, you will be expected to pay for your visit if you did not go through your PCN. It is your responsibility to contact your insurance company to see if any medical or surgical procedure requires precertification.

REFRACTION AND EXAMINATION: When vision is not normal a refraction must be done to determine whether glasses can improve vision or if the reduced vision is a result of disease. A complete exam always includes a refraction, which is not covered by most insurance. Medicare does not pay for refractions. You will be responsible to pay on the day of service.

CONTACT LENS: An eye glass prescription is not the same as a contact lens prescription. New wearers require fitting and follow up visit for which there will be a charge depending on the type contact fit; likewise, patients who have never been fitted with contacts at our clinic require a follow up visit. These charges also cover a care kit and trial pair of contact lens. Trial contacts are not available in gas permeable lens.

FINANCIAL AGREEMENT: I fully understand that I am ultimately responsible for any and all charges associated with my account. If I fail to pay any amount due, I will also be responsible for all collection fees, court costs, attorney fees, and any other charges incurred in the collection of the balance due. I also understand that my account with this provider and its doctors is considered an open account. If you have an overdue balance, payment must be made or a payment arrangement made before your visit. We do accept major credit cards.

Patient's Signature _____ Date: _____

I hereby assign, transfer, and turn over to Rayner Eye Clinic all of my rights, title, and interest to medical reimbursement benefits under insurance policy. I authorize the release of any medical information needed to determine these benefits. The authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.