EYE SPECIALISTS OF GEORGIA

777 Cleveland Ave SW, Suite 616, Atlanta, GA 30315 • 404-766-6268
6524 Professional Place, Riverdale, GA 30274 • 770-996-2096
303 Prime Point, Peachtree City, GA 30269 • 404-806-8773

Welcome! How did you hear about us?

Patient	Friend/Family	Insurance
Google	Facebook	Doctor referral
Website	Postcard	Other: _____

Patient Information

_____ _____ _____
Last Name **First Name** **Middle Initial**

_____ _____ _____ _____
Date of Birth **Age** **Sex** **Soc. Sec. #**

_____ _____ _____ _____
Home Address: Street **City** **State** **Zip**

_____ _____ _____
Home Phone **Cell Phone** **Email Address**

Marital Status: _____ **Race/Ethnicity**: _____

Preferred language: _____ **Occupation:** _____

Emergency Contact

_____
Name Relationship Phone Number

Primary Care Physician

_____
Name City State

COVID Questionnaire

In the past 14 days, have you:

1.	Come into contact with anyone known to have COVID-19?	Yes	No
2.	Had a fever?	Yes	No
3.	New shortness of breath?	Yes	No
4.	New cough?	Yes	No
5.	Decreased smell or taste?	Yes	No

Eye History

Do you wear glasses?	Yes	No
If Yes, how old are they? _____		
Do you wear contact lenses?	Yes	No
Have you ever had a major eye injury?	Yes	No

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Check any past eye conditions:

- □ None
- □ Cataracts
- □ Glaucoma
- □ Macular degeneration
- □ Diabetic eye disease
- □ Dry Eye
- □ Iritis/Uveitis
- □ Retinal tear
- □ Retinal detachment
- □ Strabismus (crossed eyes)
- □ Keratoconus
- □ Blepharitis
- □ High eye pressure
- □ Artery or vein occlusion (“stroke” in the eye)

Check any past eye surgeries:

- □ None
- □ Cataract surgery
- □ YAG laser to clean artificial lens implant
- □ Glaucoma laser (ALT, SLT)
- □ Glaucoma surgery (iStent, trabeculectomy, tube shunt)
- □ Laser iridotomy (LPI or LI)
- □ Cornea transplant
- □ LASIK or other vision correction surgery
- □ Laser for diabetic retinopathy
- □ Laser for retinal tear
- □ Retinal detachment repair
- □ Eye injections
- □ Strabismus surgery
- □ Other: _____

Check any past medical conditions:

- □ None
- □ Hypertension (high blood pressure)
- □ Hyperlipidemia (high cholesterol)
- □ Cancer: _____
- □ Heart disease
- □ Heart attack
- □ Heart surgery
- □ Arrhythmia (heart rhythm abnormality)
- □ Diabetes Type 1 or 2
- □ Stroke or TIA (mini-stroke)
- □ Migraines
- □ Seizures
- □ Asthma
- □ COPD (emphysema)
- □ COVID
- □ Sarcoidosis
- □ Other lung problems
- □ Acid reflux (heartburn)
- □ Stomach ulcer
- □ Inflammatory bowel disease
- □ Kidney failure
- □ Dialysis
- □ Prostate enlargement
- □ Osteoarthritis (‘wear-and-tear’ arthritis)
- □ Rheumatoid/autoimmune arthritis
- □ Anxiety
- □ Depression
- □ Other mental health problem
- □ Substance use disorder
- □ Thyroid disease
- □ Bleeding disorder
- □ Clotting disorder
- □ Anemia
- □ Sickle cell disease
- □ Lupus
- □ HIV
- □ Syphilis
- □ Tuberculosis
- □ Other medical problems and past surgeries:

_____

_____

_____

_____

List current medications - name AND dose: □ None

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medication allergies: _____ □ None

Are you having any of the following symptoms?

- □ New or severe headaches
- □ Frequent/severe nose bleeds
- □ Ulcers inside the mouth
- □ Ringing in the ears
- □ Neck pain
- □ Shortness of breath
- □ Chronic cough
- □ Coughing up blood
- □ Abdominal pain
- □ Bloody stools
- □ Frequent/severe diarrhea
- □ Blood in the urine
- □ Genital ulcers
- □ Swollen, painful joints
- □ New or unexplained rash
- □ Unexplained fevers
- □ Night sweats
- □ New or worsening fatigue
- □ Unintended weight loss
- □ None of the above

Smoking Status

Have you ever smoked cigarettes? **Yes**, current smoker **Yes**, former smoker **No**, never smoker

Health Measurements

	Value	**Date Checked**
● Last blood pressure reading:	_____ /_____	_____
● If diabetic, last morning blood sugar:	_____	_____
● If diabetic, last hemoglobin A1c (blood draw):	_____	_____
● If HIV+, last CD4 count:	_____	_____
● If HIV+, last viral load:	_____	_____

Vaccinations

Have you received a COVID vaccine?	**Yes**, fully vaccinated	**Yes**, 1 of 2 doses	**No**
Have you received a flu vaccine in the last year?	**Yes**	**No**	
If over 65, have you received a pneumonia vaccine?	**Yes**	**No**	**N/a**

_____ _____

Patient or Parent/Guardian Signature Date

_____ _____

Patient Name (print clearly) Parent/Guardian Name (if applicable)

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_____
Initial

NO-SHOW POLICY

If you need to reschedule or cancel your appointment, you must give at least 24 hours' notice by calling the office.

If you are unable to give 24 hours' advance notice, your **1st** missed appointment will result in a phone call to remind you about our no-show policy.

After your **2nd** missed appointment, all future appointments during the remainder of the calendar year will be scheduled on a *walk-in* basis only.

In the event of a personal or family emergency, a one-time pass may be granted at the discretion of the practice manager.

_____
Initial

INSURANCE AND BILLING POLICY

Eye Specialists of Georgia participates in many different insurance plans. It is every patient's own responsibility to be knowledgeable about the benefits of their specific plan.

Many insurance companies require a co-pay for the office visit. The **co-pay is due on the day of the visit.**

We file claims to your insurance without collecting charges, except for your co-pay, deductibles, refractions, and non-covered procedures. This is offered as a courtesy to our patients. When your insurance company sends us back an explanation of benefits (EOB), the insurance will state whether they reimburse for the remaining balance for your visit and/or procedure. If insurance denies reimbursement, for whatever reason, we will bill you, and the charges will become your responsibility to pay. We make every effort to correct errors with the insurance company before billing the patient.

Please understand that due to our patient volume and to the complex nature of insurance, we do not have the resources to pursue each patient's individual insurance problems, nor can we re-file a claim unless we made an error on the original submitted claim.

If you receive a bill from us, we will be happy to answer any questions concerning the statement, or to discuss setting up a payment plan for you.

_____
Initial

PRIVACY POLICY

I acknowledge that:

1. I have requested a personal copy and have read Eye Specialists of Georgia's Notice of Privacy Practices OR I have read the office copy and declined to receive a personal copy of Eye Specialists of Georgia's Notice of Privacy Practices.

2. If I request that Eye Specialists of Georgia send my Protected Health Information ("PHI") to anyone other than the parties listed in Eye Specialists of Georgia's Notice of Privacy Practices, I will first have to provide the practice with written authorization.

_____
Initial

DILATING DROPS

Dilating drops are used to dilate, or enlarge, the pupils of the eyes to allow the eye doctor to get a better view of the inside of the eye.

Dilating drops may temporarily blur vision and make the eyes sensitive to light. It is not possible for your doctor to predict how much your vision will be affected. We recommend bringing a driver on the day of your appointment.

Reactions to dilating drops are rare and are treatable with immediate medical attention.

I acknowledge that:

1. I authorize my doctor as well as any doctor's assistants to administer dilating drops during my visit.
2. I understand that dilating drops are necessary to complete a full eye examination.
3. If I do not agree to receive dilating drops at future visits, my eye doctor may be unable to diagnose a serious eye condition.

_____ _____

Patient or Parent/Guardian Signature | Date

_____ _____

Patient Name (print clearly) | Parent/Guardian Name (if applicable)