DOTHAN EYECARE
Patient Registration

ID# _____

REASON FOR VISIT: _____ PREFERRED PHARMACY: _____

WHAT DOCTOR REFERRED YOU TO US: _____ DATE _____

NAME		SEX ☐ M ☐ F	AGE	BIRTHDATE	MARITAL STATUS M☐ S☐ D☐ W☐
MAILING ADDRESS		SOCIAL SECURITY #		DRIVER'S LICENSE #	
CITY	STATE ZIP	☐EMPLOYED	☐RETIRED	☐ DISABLED	☐ STUDENT
EMAIL ADDRESS		EMPLOYER OR SCHOOL		OCCUPATION	
HOME PHONE	CELL	WORK		PRIMARY NUMBER	

WHICH ONE OF THE ABOVE NUMBERS CAN WE USE TO LEAVE MESSAGES REGARDING APPOINTMENT REMINDERS:

SPOUSE OR GUARDIAN INFORMATION:

NAME		RELATIONSHIP TO PATIENT	SSN #	BIRTHDATE
ADDRESS		OCCUPATION		
CITY		EMPLOYER		
HOME PHONE	WORK OR CELL PHONE	CITY	STATE	ZIP

EMERGENCY CONTACT OTHER THAN SPOUSE (REQUIRED):

Name Relationship Phone

FINANCIAL POLICY:

COMMERCIAL INSURANCE:

Payment is expected at the time of service unless we are a provider for your insurance company. It is our policy that all co-pays and/or deductible amounts are due and expected at the time of service.

Credit Cards accepted: VISA MASTERCARD DISCOVER

INSURANCE INFORMATION:

Primary _____ Secondary _____

Please present the following information to the Receptionist to make a photocopy for your chart:

All Insurance Cards Your Driver's License

AUTHORIZATIONS:

INSURANCE AND PAYMENT AUTHORIZATIONS:

I authorize **Dothan Eyecare,** to release any medical information requested by my health insurance carrier, Medicare or any other third-party payers. **Dothan Eyecare**, may contact my insurance company or health plan administrator to obtain pertinent financial information concerning coverage and payments under my policy. I hereby authorize payment of insurance benefits be made on my behalf to **Dothan Eyecare**, and assign benefits to the physician indicated on the claim.

I understand that I am responsible for any co-pays or deductibles as defined by my insurance policy, and for any "non-covered" services of my consent if deemed necessary. I accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all costs of collection, attorney fees, and/or court costs; if such be necessary. I waive now and forever my rights of exemption under the laws of the constitution of the State of Alabama and any other state.

I give **Dothan Eyecare**, its employees and/or agents "express prior consent" to contact me at any/all phone numbers, including cell phone numbers (by phone call or text message) for the purpose of treatment, insurance or payment. I authorize **Dothan Eyecare**, to release all information to my referring physician and/or primary care physician. I hereby give authorization for treatment to my physician(s) at **Dothan Eyecare**, and give permission to disclose my protected health information in order to carry out treatment, payment, and other healthcare operations.

DATE_____ **SIGNATURE** _____

(PATIENT OR RESPONSIBLE PARTY)

REV 04/20

Dothan Eyecare
optical + med spa

Brent McKinley, M.D.
Aric J. Aldridge, M.D.

Patient Name _____ Account Number _____

I, the undersigned, on behalf of the patient whose name appears above, consent to, and authorize all diagnostic and therapeutic treatments deemed necessary by the attending physician, or his staff, in accordance with today's medical standards and consent for future treatment may be revoked in writing and will not be revoked by implication.

I have been offered a copy of the Privacy Notice for Dothan Eyecare. The following people are authorized to receive medical and billing information concerning my treatment with this facility.

Name _____ Relationship _____

Name _____ Relationship _____

List any restrictions on release of information

_____

Agreed and Acknowledged – Patient signature or Personal Representation _____ Date _____

Restrictions reviewed by: _____ Chart and system notated: _____

FINANCIAL POLICY

I authorize and request that payment of any and all insurance benefits be made to Brent McKinley, M.D. and Aric J. Aldridge, M.D. I authorize Brent McKinley, M.D. and Aric J. Aldridge, M.D. to release to my insurance company and its agents any information requested to determine benefits or benefits payable.

Due to the constant changes in insurance, it is not possible for Brent McKinley, M.D. and Aric J. Aldridge, M.D. to interpret each patient's individual policy. It is your responsibility to know your individual coverage. We will be glad to assist you with determining benefits but the final responsibility belongs to the patient.

All accounts are subjected to an interest fee of 1.5% monthly, 18% a nnually for unpaid balances. Any account turned over to collections will be assessed all fees from the collection agency, as well as any attorney fees and, or court cost.

If you should need to cancel or reschedule an appointment, we ask that you call 24 hours prior to your appointment time. **There is a $15.00 fee for missed appointments.** After **three missed** appointments, a patient may be dismissed from the practice for non-compliance.

There is a **$15.00 fee for completing any forms** other than those required for processing any claims filed by Brent McKinley, M. D. and Aric J. Aldridge, M.D. to your insurance carrier. Ex: FMLA, personal policy claims, personal disability forms.

Returned checks: There is a **$30.00 fee** for a check that is returned.

Date _____

Responsible Party Signature/ Relationship _____

Dothan Eyecare
optical+med spa

PATIENT HISTORY FORMS

Brent McKinley, M.D.
Aric J. Aldridge, M.D.

Patient's Name _____ Date of Birth _____

Phone Number _____ Alternate Phone Number _____

Primary Medical Doctor _____ Optometrist *(who makes your glasses)* _____

List all Drug Allergies:

Which, if any, of the following have you ever been treated for?

Ear, Nose & Throat
- ☐ Ear Infection
- ☐ Legal Blindness
- ☐ Sinus Infection
- ☐ Vertigo

Eye
- ☐ Diabetic Retinopathy
- ☐ Mac Degeneration
- ☐ Glaucoma
- ☐ Lazy Eye

Muscluoskeletal
- ☐ Ankylosing Spondylitis
- ☐ Rheumatoid Arthritis
- ☐ OsteoArthritis
- ☐ Fibromyalgia

Cardio
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ High Cholesterol
- ☐ Stroke/TIA
- ☐ Defibrillator

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Sleep Apnea

Endocrine, Metabolic
- ☐ Thyroid disease
- ☐ Diabetes Type _____
- ☐ Last blood sugar _____
- ☐ Last AIC _____
- ☐ Date checked _____
- ☐ Pituitary Gland
- ☐ Sarcoidosis
- ☐ Lupus
- ☐ Cancer
- ☐ Military History _____

_____

Gastronintestinal
- ☐ Ulcer
- ☐ Diverticulitis
- ☐ Hepatitis
- ☐ Hernia
- ☐ Reflux disease
- ☐ Liver disease
- ☐ Crohn's

Genitourinary
- ☐ Prostate disease
- ☐ Kidney disease
- ☐ Currently pregnant
- ☐ Currently nursing

Neurological
- ☐ Alzheimer's
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Seizure
- ☐ Tremors

Psychiatry
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Dementia

Skin
- ☐ Cancer
  Type _____
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rosacea

Blood Disorders
- ☐ HIV
- ☐ AIDS
- ☐ Anemia
- ☐ Sickle-Cell
- ☐ Hemophelia

- ☐ Are you pregnant or nursing?
- ☐ Have you traveled outside the U.S. in the past two years?
- ☐ Other issue, please explain:

_____
_____
_____
_____

☐ **NONE OF THE ABOVE**

Height _____ **Weight** _____

Patient Signature: _____ Date: _____

FAMILY HISTORY

Do know of any blood relatives who has or had: (check and give realtionship)

- ❑ Macular Degeneration _____
- ❑ Lazy Eye _____
- ❑ Asthma _____
- ❑ Glaucoma _____
- ❑ Heart Disease _____
- ❑ Goiter _____
- ❑ Cancer _____
- ❑ High Blood Pressue _____
- ❑ Alcholoism _____
- ❑ Diabetes _____
- ❑ Tuberculosis _____
- ❑ Tuberculosis _____
- ❑ Stroke _____
- ❑ None of the Above

VACCINATION HISTORY

Have you ever had Penumonia vaccination? ☐ Yes ☐ No

Have you ever had a Flu Shot? ☐ Yes ☐ No

Have you ever had Botox Filler/Cosmetic Procedure? ☐ Yes ☐ No

Do you wear Contact Lens? ☐ Yes ☐ No

SOCIAL HISTORY

Do you smoke? ☐ Yes, packs per day _____ ☐ No ☐ Former smoker, how long? _____

Do you drink alcohol? ☐ Yes ☐ No **How much** ☐ Daily ☐ Weekly ☐ Occasionally

Do you drink caffeinated beverages? ☐ Yes, cups per day? _____ ☐ No

Do you drive? ☐ Yes ☐ No

Do you live: ☐ alone ☐ or with Family?

PAST SURGICAL HISTORY

List of all surgeries

Type of Surgeries	Year	Surgeons

CURRENT MEDICATION LIST

Include any vitamins or non-prescription medicines)

NAME OF MEDICATION	DOSAGE (ex. mg, mcg)	DIRECTIONS

ALLERGIES: _____