Talley Eye Institute

Demographic and Insurance Information
www.talleyeyeinstitute.com

Name: _____ **Today's Date:** ____/____/____ **Birthdate:** ____/____/____ **Age:** _____

Address: _____ **E-Mail:** _____

City: _____ **State:** _____ **Zip:** _____**Phone:** _____ **Sex:** ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed **Social Security No.:** _____

Race: ☐ White ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Native Hawaiian/Other Pacific Islander

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Language Preference: ☐ English ☐ Spanish ☐ Other _____

Employer: _____ **Work Phone:** _____

Notify in case of emergency: _____ **Phone:** _____ **Relationship:** _____

Family Doctor: _____ Phone: _____ Date of last doctor visit: ____/____/____

Referring Doctor: _____ Phone: _____

Is this a Workers' Comp injury? ☐ Yes ☐ No If YES, what is the nature of the injury? _____

Date of Injury: ____/____/____ Has the accident been reported to your employer? ☐ Yes ☐ No

Employer Name: _____ Employer Address: _____

Employer Phone: _____ Contact Person: _____

Is this an Auto Liability Accident injury? ☐ Yes ☐ No If YES, what is the nature of the injury? _____

Where were you when injury/accident occurred? _____

What were you doing when injury/accident took place? _____

Auto Insurance Company Name: _____ Phone: _____

Contact Person: _____ Claim Number (if known): _____

RESPONSIBLE PARTY'S INFORMATION (if a Minor, Guardian or Power of Attorney)

Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____

Date of Birth: ____/____/____ Social Security No.: _____

PRIMARY INSURANCE INFORMATION

Name of Insurance: _____ Name of Cardholder: _____

ID#: _____ Cardholder's Social Security No.: _____ Cardholder's Birthdate ____/____/____

Relationship to patient: _____ Cardholder's Employer: _____

SECONDARY INSURANCE INFORMATION

Name of Insurance: _____ Name of Cardholder: _____

ID#: _____ Cardholder's Social Security No.: _____ Cardholder's Birthdate ____/____/____

Relationship to patient: _____ Cardholder's Employer: _____

I understand that, even though I may have some type of insurance and authorize this office to submit charges on my behalf, I am also responsible for payment. I hereby assign to the doctor, all payments for medical services rendered to me. I am aware that a co-payment may be required at each visit, and if there is no insurance coverage, payment in full is required for services unless prior payment arrangements have been discussed. I will also be responsible for all collection fees, should my account be assigned to a collection agency.

Signature _____ Date _____

812.424.2020 / 812.424.3000 (fax)

Talley Eye Institute

Medical and History Record
www.talleyeyeinstitute.com

Height: _____
Weight: _____

Name: _____ **Today's Date:** ____/____/____ **Birthdate:** ____/____/____ **Age:** _____

PRESENT ILLNESS

Do you currently have any problems in the following areas?

	YES	NO		YES	NO		YES	NO
EYES								
Blurred vision	☐	☐	Excessive tearing/watering	☐	☐	Are you having any difficulty?		
Loss of vision	☐	☐	Infection of eye/eyelid	☐	☐	Reading small print	☐	☐
Double vision	☐	☐	Dryness	☐	☐	Driving at night	☐	☐
Fluctuating vision	☐	☐	Redness	☐	☐	Halos around headlights	☐	☐
Glare/light sensitive	☐	☐	Itching	☐	☐	Reading traffic lights	☐	☐
Mucous discharge	☐	☐	Eye pain/soreness	☐	☐	Doing hobbies	☐	☐
Eye irritation	☐	☐	Stye, chalazion	☐	☐	Watching TV	☐	☐

Are you currently having any problems in the following areas OR ever been treated for?

	CURRENT	PAST		CURRENT	PAST		CURRENT	PAST
Constitutional			Gastrointestinal			Respiratory		
childbirth	☐	☐	gastric reflux/GERD	☐	☐	asthma	☐	☐
fever	☐	☐	colon cancer	☐	☐	COPD	☐	☐
obesity	☐	☐	stomach ulcers	☐	☐	emphysema	☐	☐
Integumentary (Skin)			nausea/vomiting	☐	☐	lung cancer	☐	☐
breast cancer	☐	☐	Genitourinary			sarcoidosis	☐	☐
skin cancer	☐	☐	cervical cancer	☐	☐	Endocrine		
Musculoskeletal			uterine cancer	☐	☐	diabetes	☐	☐
muscle/joint pain	☐	☐	kidney disease	☐	☐	pancreatic cancer	☐	☐
lupus	☐	☐	prostate cancer	☐	☐	thyroid cancer	☐	☐
osteoarthritis	☐	☐	prostate hypertrophy	☐	☐	thyroid problems	☐	☐
rheumatoid arthritis	☐	☐	Neurological			weight loss	☐	☐
Ears, Nose, Throat			migraines	☐	☐	weight gain	☐	☐
difficulty hearing	☐	☐	Alzheimer's	☐	☐	Hematologic/Lymphatic		
ear pain	☐	☐	seizure disorder	☐	☐	anemia	☐	☐
nasal congestion	☐	☐	stroke/CVA	☐	☐	bleeding disorder	☐	☐
nasal bleeding	☐	☐	Cardiovascular			blood cancer	☐	☐
chronic cough	☐	☐	high blood pressure	☐	☐	leukemia	☐	☐
dry throat/mouth	☐	☐	congestive heart failure	☐	☐	sickle cell disease	☐	☐
Allergic/Immunologic			heart attack	☐	☐	Psychiatric		
hay fever symptoms	☐	☐	heart disease	☐	☐	anxiety	☐	☐
immune problems	☐	☐	high cholesterol	☐	☐	depression	☐	☐
seasonal allergies	☐	☐	irregular heart beat	☐	☐	dementia	☐	☐

Other Past/Present Conditions: _____

PAST OCULAR HISTORY

- ☐ No significant illnesses
- ☐ Bell's palsy
- ☐ cataract
- ☐ chalazion/stye
- ☐ corneal laceration/scratch
- ☐ corneal ulcer
- ☐ diabetic retinopathy
- ☐ double vision
- ☐ dry eye syndrome
- ☐ eyelid turned inward
- ☐ eyelid turned outward
- ☐ foreign body removed
- ☐ Fuchs' dystrophy
- ☐ glaucoma
- ☐ herpes
- ☐ iritis
- ☐ lazy eye (amblyopia)
- ☐ macular degeneration
- ☐ nerve palsy
- ☐ ocular allergies
- ☐ pterygium
- ☐ retinal detachment
- ☐ uveitis
- ☐ Other _____

PAST OCULAR SURGERY

- ☐ No prior eye surgery
- ☐ cataract surgery
- ☐ corneal surgery
- ☐ eye muscle surgery
- ☐ eyelid surgery
- ☐ glaucoma surgery
- ☐ laser eye surgery
- ☐ LASIK/refractive surgery
- ☐ pterygium surgery
- ☐ retinal surgery
- ☐ Other _____

OTHER PAST SURGERY

- ☐ No prior surgery
- ☐ appendectomy
- ☐ back surgery
- ☐ brain surgery
- ☐ breast surgery
- ☐ carotid surgery
- ☐ colon surgery
- ☐ coronary artery bypass
- ☐ dental surgery
- ☐ gallbladder
- ☐ heart surgery
- ☐ hip surgery
- ☐ hysterectomy
- ☐ implanted defibrillator
- ☐ intestine surgery
- ☐ kidney surgery
- ☐ lung surgery
- ☐ lymph node surgery
- ☐ mastectomy
- ☐ nose surgery
- ☐ orthopedic surgery
- ☐ pacemaker
- ☐ stomach surgery
- ☐ thyroid surgery
- ☐ tonsillectomy
- ☐ tumor removed
- ☐ Other _____

812.424.2020 / 812.424.3000 (fax)

PAST INFECTION HISTORY

☐ None ☐ Chlamydia ☐ Hepatitis C ☐ Histoplasmosis ☐ STD
☐ AIDS ☐ Hepatitis A ☐ Herpes Simplex ☐ HIV ☐ Syphilis
☐ Chicken Pox ☐ Hepatitis B ☐ Herpes Zoster ☐ Rheumatic Fever ☐ Tuberculosis
☐ Other ______________________________

FAMILY HISTORY

	YES	NO	RELATIONSHIP TO PATIENT		YES	NO	RELATIONSHIP TO PATIENT
☐ blindness	☐	☐	______________	retinal detachment	☐	☐	______________
☐ heart attack	☐	☐	______________	cancer	☐	☐	______________
☐ cataract	☐	☐	______________	stroke	☐	☐	______________
☐ high blood pressure	☐	☐	______________	diabetes	☐	☐	______________
☐ glaucoma	☐	☐	______________	thyroid disease	☐	☐	______________
☐ heart problems	☐	☐	______________	Fuchs' dystrophy	☐	☐	______________
☐ macular degeneration	☐	☐	______________	Other ________	☐	☐	______________

SOCIAL HISTORY

	YES	NO	
Do you currently wear glasses?	☐	☐	How long have you had the current pair? ☐ weeks ☐ months ☐ years
Do you currently wear contacts?	☐	☐	What type of contacts? ☐ hard ☐ soft ☐ gas permeable
Have you ever tried to wear contacts?	☐	☐	
Do you drive?	☐	☐	
Do you drink alcohol?	☐	☐	
Do you use illegal drugs?	☐	☐	

Are you a ☐ current every day smoker How many packs per day? ____________
☐ former smoker When did you quit? ____________
☐ never smoker

What is your occupation? ______________________________

If retired, what was your occupation? ______________________________

MEDICATIONS

List all current medications you are taking (includes prescription, over-the-counter, herbals, vitamins, mineral supplements, dietary supplements). Attach a list if necessary.

Name:	Dosage:	How often?
By ☐ mouth ☐ inject ☐ patch ☐ ________	Prescribing Doctor:	Taken for?
Name:	Dosage:	How often?
By ☐ mouth ☐ inject ☐ patch ☐ ________	Prescribing Doctor:	Taken for?
Name:	Dosage:	How often?
By ☐ mouth ☐ inject ☐ patch ☐ ________	Prescribing Doctor:	Taken for?
Name:	Dosage:	How often?
By ☐ mouth ☐ inject ☐ patch ☐ ________	Prescribing Doctor:	Taken for?
Name:	Dosage:	How often?
By ☐ mouth ☐ inject ☐ patch ☐ ________	Prescribing Doctor:	Taken for?
Name:	Dosage:	How often?
By ☐ mouth ☐ inject ☐ patch ☐ ________	Prescribing Doctor:	Taken for?

What pharmacy do you use? ______________________ pharmacy phone: ______________

Do you have allergies to any medications? ☐ Yes ☐ No

If YES, list medications and the reaction to them (includes difficulty breathing, confusion, cough, dizziness, swelling of limbs, headache, lethargy, nausea/vomiting, hives/rash)

____

____

Have you ever had a reaction to anesthetic? ☐ Yes ☐ No

Do you currently or have you ever used Flomax (Tamsulosin)? ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No

Are you allergic to latex? ☐ Yes ☐ No

Do you have MRSA/VRE? ☐ Yes ☐ No

TALLEY MEDICAL-SURGICAL EYE CARE ASSOCIATES
6149 E. Columbia St • EVANSVILLE IN 47715
812.424.2020 • 800.489.2020 • 812.424.3000 fax • www.talleyeyeinsitiute.com

RESPONSIBILITY, CONSENT & ASSIGNMENT OF BENEFITS

MEDICAL CONSENT. I, the undersigned, being the person whose name appears hereafter designated as "patient" or being a person legally authorized to consent to services on behalf of the patient, do hereby consent and authorize the doctors of Talley Medical-Surgical Eye Care Associates, PC ("Doctor Office") to: (1) discuss, document and securely store my health history/information and (2) provide an in-office or bedside examination of my eyes and/or body as deemed necessary by my doctor in order to appropriately arrive at a diagnosis and treatment plan. I understand that some preliminary information gathering and basic testing done in the office is often performed by members of my doctor's staff as well as by the doctor him(her)self and this routine work-up often includes the instillation of eye drops for various reasons- such as to check eye pressure and to dilate the pupils. Because of this, this consent and authorization also extends to and includes: staff doctors, interns/students, nurses/nurse's aides, technicians and agents and employees of the Doctor Office providing services to the patient. I understand that the patient is under the care of the attending doctor and that such doctor is responsible for determining the nature and course of treatment for the patient. The attending doctor will recommend treatment for the patient and the patient will have to decide whether to follow those recommendations or not. The consent given here **does NOT** extend to initiation of any oral or IV medications nor any surgical procedures or injections performed whether in the Office or a surgical facility. Separate consent must be obtained for any of these procedures.

RELEASE OF INFORMATION. The undersigned agrees that to the extent necessary to determine responsibility for payment and to obtain reimbursement, the Doctor Office may disclose portions of the patient's record, including their medical records, to any person or entity which is or may be responsible for all or any portion of the Doctor's Office charges, including but not limited to insurance companies, health care service plans, worker's compensation carriers, medical or utilization review organization designated by any of the foregoing, or to any other person or entity as necessary in connection with such payment or reimbursement. I authorize any holder of medical or other information about me to release same and copies of any medical records to Doctor's Office, the Health Care Financing Administration, its agents or carriers, and my insurance carrier(s), necessary to determine benefits and/or to process claims for this and all related claims on my behalf, now or in the future. I request my insurance company(ies) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my doctor on my behalf.

HIPAA NOTICE. I have been given the opportunity to review a Notice of Privacy Practice disclosing how my patient health information may be used and disclosed, and how I can get access to my individually identifiable health information.

DISPOSITION OF TISSUE, ETC. I authorize the Doctor Office to retain, preserve, and use for scientific purposes or disposal at the convenience of the Doctor Office, any specimens or tissues taken during my treatment.

MEDICARE CERTIFICATION. I certify that the information given by me for payment under Title XVIII of the Social Security Act is correct. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). I authorize my doctor who treats me, to release information from my medical records to the Social Security Administration and/or the Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the processing of claims for medical benefits. I permit a copy of this authorization to be used in place of the original, and I request that payment of authorized benefits be made directly to my doctor treating me, on my behalf.

PAYMENT GUARANTEE. In consideration of the services delivered by the Doctor's Office and/or doctor, the undersigned guarantees payment of the account, and agrees to pay the same at the time of visit if such account is not paid by a private or governmental insurance carrier, and to pay any balance due promptly upon receipt of my first statement. I agree to comply with the terms of my insurance coverage, including payment of co-pays at the time services are rendered. I understand that all accounts are the full responsibility of the patient and/or the patient's responsible party. I understand that the Doctor's Office may add a finance charge to any outstanding balance. If the amounts due to the Doctor's Office for services rendered become delinquent and do not have agreed upon financial arrangements with the Doctor's Office, these accounts may be submitted to a collection agency or attorney for collection. I agree that I will pay all attorney fees and court costs incurred by the Doctor Office in the collection of all sums due. If I provide the Doctor Office or its agents with my cell phone number, I authorize the Doctor Office or its agents to call our cell phone either manually or by auto-dialer in order to collect any amounts that I owe. I understand that any email that I provide is my personal email and I authorize the Doctor Office to contact us via that email address.

MEDICAID. If this service is to be covered under a Medicaid Program, I understand that I must show my current Medicaid card prior to seeing the doctor, and to pay any spend down that has not been met at time of service. I agree and understand that if I am a QMB recipient, that Medicaid will extend coverage to payment of Medicare co-insurance and/or deductible only, and that I am responsible for services and supplies not covered or denied by Medicare. I further agree and understand that I am being informed, prior to receipt of service, that I may be responsible for services that the Indiana Medicaid Program determines not to be a covered benefit. I agree and understand that if I do not have my current Medicaid card that payment in full is required for this visit at the time services are rendered.

ASSIGNMENT OF BENEFITS. In consideration of services rendered to be rendered from time to time by Doctor, I hereby authorize, request, and assign payment directly to the Doctor's Office and/or Doctor covering this period of treatment and future treatment, by all insurance carriers with whom I have coverage or from whom benefits are, or may become, payable to me, including settlements or judgments flowing from the incident for which I am receiving treatment. This assignment is a relinquishment and assignment of all legal or equitable interest which I have in any insurance benefits which exist by reason or contract or otherwise, including but not limited to, Major Medical and other special coverages, and including the right to sue or make claim for said benefits; this assignment is irrevocable except upon full payment of all indebtedness, or by express written agreement between the Doctor Office, and the undersigned; this assignment does not constitute payment for indebtedness and does not relieve the undersigned from liability for unpaid indebtedness. In the event that insurance benefits to which I am entitles are paid directly to me for indebtedness incurred by me or a member of my family, or a person for whom I am financially responsible, I agree that I will immediately deliver all such benefit received.

PRIOR AUTHORIZATION. I understand that some insurance companies require prior authorization for certain procedures, and that maximum reimbursement and coverage may not be received if prior authorization is not obtained. I assume the responsibility of obtaining such authorization if necessary. NOTICE: Your health insurance plan may require you to obtain some medical services from certain providers in order to be fully covered for those services under your plan. Please be sure to review your health care insurance plan before receiving any services at the Doctor's Office. In most cases, your insurance card will list a telephone number that you may call to obtain your health insurance benefit coverage's and any restrictions on choosing a provider. Talley Medical-Surgical Eye Care Associates offers a full range of the services you may need; however, in order to receive maximum insurance payment, you need to know your health insurance benefits coverage and which providers the insurance will fully pay.

THE UNDERSIGNED CERTIFIES THAT THEY HAVE READ AND UNDERSTAND THE FOREGOING AND EITHER IS THE PATIENT NAMED OR IS DULY AUTHORIZED BY THE PATIENT OR BY LAW TO ACCEPT THE TERMS ON THE PATIENT'S BEHALF.

_____	_____	_____
Signature of Patient / Legal Representative	Date	Relationship of Legal Representative

_____	_____	_____	_____
Signature of Guarantor (if other than above)	Date	Signature of Witness	Date

_____	_____
Policyholder (if other than Guarantor)	Date

CONTACT LENS REMOVAL POLICY

Cataract and Refractive Surgery Evaluations ONLY

The doctors and staff of Talley Eye Institute want to make every effort to ensure you have the best visual outcome following any cataract or refractive procedure. Therefore, we ask that you adhere to the recommended clinical protocol for the removal of Contact Lenses in advance of your evaluation.

Wearing contact lenses, especially over a long period of time, may temporarily alter the shape of the cornea on the front of the eye. This change in shape may influence critical measurements taken in preparation for your procedure.

It is essential that contact lenses are removed and your eyes allowed to "rest" for a period of time in advance of your appointment. *If contact lenses are worn during the recommended removal period, there is a strong possibility that the measurements and/or procedure will need to be rescheduled for a later date.*

Please adhere to the following guidelines for contact lens removal:

Hard Contacts, including Rigid Gas Permeables (RGPs), must be removed for a minimum of **4 weeks** before a cataract or reactive surgery evaluation.

Toric Soft Contacts must be removed for a minimum of **2 weeks** before a cataract or refractive surgery evaluation.

Regular Soft Contacts (non-toric) must be removed for a minimum of **1 week** before a cataract or refractive surgery evaluation.

If you have questions or concerns related to these Contact Lens removal guidelines, please contact our medical staff at 812-424-2020.