



**Main:** 136 W. Cherry St  
Jesup, GA 31545

Elizabeth Crandall, MD  
Ophthalmology

**Brunswick:** 17 Professional Dr  
Suite 100  
Brunswick, GA 31520

**Phone:** (912) 559-2467  
**Fax:** (912) 559-2473  
[www.crandalleye.com](http://www.crandalleye.com)

Dear \_\_\_\_\_,

Thank you for choosing us to provide you with your eye care needs. We know you have other choices and we are extremely happy you've given us the opportunity!

Since you are a new patient, we have attached our new patient paperwork forms. We would greatly appreciate you filling out the attached forms so that we can get you seen in a timely manner. We realize it's a lot of paperwork, but we promise all this information is pertinent to ensuring we don't miss anything in your medical history!

For your first visit, you can expect an average time of 1 hour for the complete visit. We strive to be very thorough with our new patient exams so that your future visits will be a breeze! During your first visit, **you will also be dilated**. If you haven't been dilated before, you can expect your vision to be a bit blurry for 3-4 hours after your visit. If you're uncomfortable driving afterwards, we suggest you have a wonderful friend or partner accompany you to your visit. We also advise you to bring a pair of sunglasses, or we can provide some for you.

Since we are a medical clinic, we accept all medical insurance, and some vision plans such as EyeMed and VSP. Since Dr. Crandall is a medical doctor we bill medical insurance as your primary insurance, just like your primary care doctor. Your vision coverage will only cover exams that do not result in **ANY** medical diagnosis. Exams covered by vision insurance only provide and eye exam for glasses. With an extra charge for a contact lens exam. Please have all applicable co-pays and deductibles for your visit as they will be due at the time of service.

If you are wanting contacts, there is a separate exam that can be done during your eye exam. The fee for the contact lens fitting exam is \$95 and isn't covered by medical insurance, but may be at a reduced rate through your vision insurance.

Finally, please bring your driver's license, insurance cards, and list of medications with you so we can enter the information we need into our system. If you are getting fitted for contacts, please bring your current contact lens boxes with you.

Thank you very much for choosing us and we look forward to your visit!

Regards,

Elizabeth Crandall, MD



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**Date:** \_\_\_\_\_

**How Did You Hear About Us:**  Newspaper  Radio  Friends/Family  Dr. Referral

**Other:** \_\_\_\_\_

**Patient Information:**

**First Name:** \_\_\_\_\_ **Middle:** \_\_\_\_\_ **Last:** \_\_\_\_\_

**Marital Status:** Single Married Divorced Widowed **Gender:** Male / Female

**Language:** English Spanish **Race:** \_\_\_\_\_ **Ethnicity:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Driving License #:** \_\_\_\_\_ **State:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zipcode:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Home Phone #:** \_\_\_\_\_ **Work Phone #:** \_\_\_\_\_ **Mobile #:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **Referring Physician:** \_\_\_\_\_

**Perferred Pharmacy:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_ **Zipcode:** \_\_\_\_\_

**Emergency Contact:**

**Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**If Minor, Parent Name:** \_\_\_\_\_

**Insurance Information:**

**Primary Insurance Company:** \_\_\_\_\_ **ID #:** \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_ **ID #:** \_\_\_\_\_

**Eye History**

Do you wear (Check box that applies)

Last Eye Exam Date: \_\_\_\_\_

- None                       Glasses                       Contact Lenses                       Glasses and Contact Lenses

Others: \_\_\_\_\_

**Please Mark Any Conditions YOU Have Presently or Have Had In The Past**

- |                                    |   |
|------------------------------------|---|
| <input type="checkbox"/> Dry Eyes  | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Glaucoma  | <input type="checkbox"/> Retinal Detachment   |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Keratoconus          |

Others: \_\_\_\_\_

**Please Mark Any Condition YOUR FAMILY Member or Blood Relative Have Presently or Have Had In The Past**

- |                                    |   |
|------------------------------------|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Keratoconus          |
| <input type="checkbox"/> Dry Eyes  | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Glaucoma  | <input type="checkbox"/> Retinal Detachment   |

Others: \_\_\_\_\_

- Betadine Allergy (Iodine)                       Latex Allergy

<p><b><u>Distance Vision, Difficulty in:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Viewing TV, reading closed caption, news scrolls on TV</li> <li><input type="checkbox"/> Seeing street signs</li> <li><input type="checkbox"/> Driving</li> <li><input type="checkbox"/> Driving at night</li> <li><input type="checkbox"/> Driving due to glare from headlights or sun</li> <li><input type="checkbox"/> Reading/viewing Blackboard</li> <li><input type="checkbox"/> Recognizing people</li> <li><input type="checkbox"/> Other: _____</li> </ul>	<p><b><u>Eyelids:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Itching</li> <li><input type="checkbox"/> Burning</li> <li><input type="checkbox"/> Red</li> <li><input type="checkbox"/> Swelling</li> <li><input type="checkbox"/> Other: _____</li> </ul>
<p><b><u>Near Vision, Difficulty in:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Reading fine print, books, news paper, instructions etc.</li> <li><input type="checkbox"/> Reading fine labels (e.g. medication labels)</li> <li><input type="checkbox"/> Other: _____</li> </ul>	<p><b><u>Ocular (Eyeballs):</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Dry Eyes</li> <li><input type="checkbox"/> Tearing</li> <li><input type="checkbox"/> Gritty eyes/ Mild Foreign Body Sensation</li> <li><input type="checkbox"/> Burning</li> <li><input type="checkbox"/> Itching: <input type="checkbox"/> Mild <input type="checkbox"/> Severe <input type="checkbox"/> Seasonal Allergies</li> <li><input type="checkbox"/> Redness</li> </ul>
<p><b><u>Flashing Lights:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> No Flashing Lights</li> <li><input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing</li> <li><input type="checkbox"/> Same <input type="checkbox"/> New onset</li> <li><input type="checkbox"/> Sparks</li> <li><input type="checkbox"/> Lightning Bolts</li> <li><input type="checkbox"/> Arcs – lasting seconds</li> <li><input type="checkbox"/> Strobe lights many minutes or longer</li> <li><input type="checkbox"/> Visual Distortion</li> </ul>	<p><b><u>Floaters:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> No Floaters <input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing <input type="checkbox"/> Same</li> <li><input type="checkbox"/> New onset</li> <li><input type="checkbox"/> Cobwebs</li> <li><input type="checkbox"/> Black spots</li> </ul>
<p><b><u>Double vision:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Near</li> <li><input type="checkbox"/> Far</li> </ul>	<p><b><u>Headaches:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Associated with visual tasks</li> <li><input type="checkbox"/> Wake up with headaches</li> </ul> <p><b><u>Loss of vision:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Amaurosis fugax</li> <li><input type="checkbox"/> Last Minutes</li> <li><input type="checkbox"/> Complete loss of vision</li> <li><input type="checkbox"/> Loss of color vision</li> </ul>



**Medications:**

No Medications

**By Mouth (Please List):**

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**Eye Drops (Please List):**

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**Drug Allergies (Please List):**

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**Surgeries (Please List):**

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**Eye Surgeries (Please List):**

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Which Eye (Right/Left)

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Which Eye (Right/Left)

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Which Eye (Right/Left)

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Which Eye (Right/Left)

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Which Eye (Right/Left)

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Which Eye (Right/Left)

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Which Eye (Right/Left)

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Which Eye (Right/Left)

Additional Information: \_\_\_\_\_

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## **MEDICAL VS. VISION POLICY**

Patient \_\_\_\_\_ Acct #: \_\_\_\_\_ Date: \_\_\_\_\_

Is this a **Routine** refractive or **Medical** eye examination?

**Routine Vision (Refractive) Coverage:** Your “vision” insurance (Eyemed or VSP) is intended to provide you with a baseline, “routine” eye evaluation and update your glasses prescription **ONLY**. If the doctor discovers any medical eye problem during a “routine” exam, the visit is now a medical exam and will be billed to your medical insurance. This is based solely on the reason for requesting the exam and the underlying diagnoses. Dr. Crandall is a Medical Doctor and Surgeon, and is trained to address your medical issues first and foremost, whether known or unknown before the exam. Your “vision” insurance is a supplemental insurance and secondary to your medical insurance.

**Patient Responsibilities:** Since your medical insurance may be billed for the exam all applicable copays and deductibles apply. Please understand that each patient’s insurance coverage varies and Crandall Eye Physicians and Surgeons cannot be held responsible for knowing every patient’s coverage.

**Medical Eye Examination Coverage:** If you have an eye condition or complaints such as but **NOT** limited to:

Cataracts

Dry Eyes

High Blood Pressure

Flashes and Floaters

Double vision

Macular Degeneration

Cornea Problems

Itching, Burning Eyes

Pink Eye

Pain

Glaucoma

Diabetes

Headaches

Something in Eye

I understand that if **ANY** of the above conditions or complaints exist, this examination will be billed to my medical insurance.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship if not signed by patient

  
**Crandall Eye**  
Physicians and Surgeons

*Thank you for trusting your eye health to us*



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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### **PAYMENT POLICIES**

We need your assistance and understanding of our payment policy. As a courtesy, Crandall Eye Physicians and Surgeons will bill most insurances. However, the patient is responsible for any non-covered or unpaid balances and any referral numbers or pre-authorizations (example: Tricare) not provided to our office prior to the appointment. Your insurance coverage is a contract between YOU and YOUR insurance company. All services are filed with your insurance carrier providing you provide all the pertinent information to our office that is needed. If all pertinent information is not received prior to the appointment then Crandall Eye Physicians and Surgeons has the right to reschedule the appointment. Insurance co-pays and deductibles are expected when services are rendered. We accept cash, check, CareCredit, and all other major credit cards. If checks are returned there will be a \$25.00 service charge.

Initial \_\_\_\_\_

If charges are denied, the patient is financially responsible for the charges incurred. If there is a need to set up payment arrangements, the billing department should be contacted by the patient or their representative. If no payment has been received after 90 days from the date of service, necessary collection procedures will be initiated. If the account is turned over for collection, in addition to your outstanding balance, there will be a 25% fee charged by the collections agency as well as any legal or court costs incurred, that you will be responsible for. We are happy to provide any counseling on our billing practices, however, if your account is not paid within 60 days you will be responsible for balance plus a monthly finance charge of 1.5% per month.

Initial \_\_\_\_\_

### **CASH PAY PATIENTS**

Patients without medical or vision insurance are accepted, and payment in full at the time services are rendered is required. We do offer a discount to those patients that are paying cash.

Initial \_\_\_\_\_

### **CANCELLATION AND NO SHOW POLICY**

In order to be respectful of the medical needs of all our patients, please be courteous and call our office promptly if you are unable to attend an appointment. This time slot will be reallocated to someone who is in urgent need of treatment. Crandall Eye Physicians and Surgeons reserves the right to reschedule the appointment if you are more than 20 minutes late. A failure to be present for a scheduled appointment will be recorded in the patient's chart as a "no show". Excessive no shows and/or cancellations could result in a charge of \$25.00 and/or dismissal from the practice.

Initial \_\_\_\_\_





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## **NOTICE OF PRIVACY PRACTICES -- SUMMARY AND ACKNOWLEDGEMENT**

We will use and disclose your health information in order to:

- Treat you or assist other healthcare providers in treating you.
- Obtain payment for our services and to allow insurance companies to process claims for services rendered to you.
- Comply with quality assessments and licensing requirements.

A written authorization will be requested to provide your private health information (PHI) for any reasons other than those stated above.

As a patient you have the rights to:

- Have access to and/or a copy of your health information
- Receive an accounting of certain disclosures we have made of your PHI
- Request restrictions as to how your PHI is used or disclosed
- Request that we communicate with you in confidence
- Request that we amend your health information
- Receive notice of our privacy practices

At any time you can request a copy of the full version of our privacy practices, please let a staff member know so that we can get that for you.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below:

Privacy Officer, Justin Crandall

Phone number: (912)559-2467 Fax number: (912) 559-2473

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Office for Civil Rights

<http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html>

I hereby understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that my PHI will only be used for the reasons stated above, unless written notification is given. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

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\_\_\_\_\_  
Patient or Guardian's Signature

\_\_\_\_\_  
Date

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Printed Name