Crandall Eye
Physicians and Surgeons

Jesup: 136 W. Cherry St
Jesup, GA 31545

Elizabeth Crandall, MD
Ophthalmology

Phone: (912) 559-2467
Fax: (912) 559-2473
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 Dr. Crandall is a medical doctor we bill medical insurance as your primary insurance, just like your primary care doctor. Please have all applicable co-pays and deductibles for your visit as they will be due at the time of service. Dr. Crandall does not accept vision insurance (Eyemed, VSP, Davis, etc.) but those plans may have out-of-network benefits you can use for glasses.

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.

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 #:**_____

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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 being. 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 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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Jesup, GA 31545

Brunswick: 17 Professional Dr
Suite 100
Brunswick, GA 31520

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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*.

_____
_____
Patient or Guardian’s Signature Date

_____
Printed Name

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

□ Dry Eyes	**□ Macular Degeneration**
□ Glaucoma	**□ Retinal Detachment**
□ Cataracts	**□ Keratoconus**

□ Others: _____

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

□ Cataracts	**□ Keratoconus**
□ Dry Eyes	**□ Macular Degeneration**
□ Glaucoma	**□ Retinal Detachment**

□ Others:_____

□ Betadine Allergy (Iodine) **□ Latex Allergy**

Distance Vision, Difficulty in:

□ Viewing TV, reading closed caption, news scrolls on TV

□ Seeing street signs

□ Driving

□ Driving at night

□ Driving due to glare from headlights or sun

□ Reading/viewing Blackboard

□ Recognizing people

□ Other:_____

Near Vision, Difficulty in:

□ Reading fine print, books, news paper, instructions etc.

□ Reading fine labels (e.g. medication labels)

□ Other:_____

Flashing Lights:

□ No Flashing Lights

□ Increasing **□ Decreasing**

□ Same **□ New onset**

□ Sparks

□ Lightning Bolts

□ Arcs – lasting seconds

□ Strobe lights many minutes or longer

□ Visual Distortion

Double vision:

□ Near

□ Far

Eyelids:

□ Itching

□ Burning

□ Red

□ Swelling

□ Other:_____

Ocular (Eyeballs):

□ Dry Eyes

□ Tearing

□ Gritty eyes/ Mild Foreign Body Sensation

□ Burning

□ Itching: □ Mild □ Severe □ Seasonal Allergies

□ Redness

Floaters:

□ No Floaters □ Increasing □ Decreasing □ Same

□ New onset

□ Cobwebs

□ Black spots

Headaches:

□ Associated with visual tasks

□ Wake up with headaches

Loss of vision:

□ Amaurosis fugax

□ Last Minutes

□ Complete loss of vision

□ Loss of color vision

Primary Care Physician:

_____

Medical Conditions:

Please mark any condition YOU have presently or have had in the past:

□ High Blood Pressure □ Uncontrolled?

□ Heart Problem

□ Arthritis □ RA □ OA

□ Lung Problems

□ Stroke

□ Thyroid Problems

□ Diabetes □ Diet □ Non-Insulin Dependent □ Insulin Dependent

□ Increased Cholesterol (LDL)

□ Cancer

□ Lupus

□ Others:_____

Medical Conditions:

Conditions YOUR FAMILY/blood relative have presently or have had in the past:

□ High Blood Pressure □ Uncontrolled?

□ Heart Problem

□ Arthritis □ RA □ OA

□ Lung Problems

□ Stroke

□ Thyroid Problems

□ Diabetes □ Diet □ Non-Insulin Dependent □ Insulin Dependent

□ Increased Cholesterol (LDL)

□ Ulcers

□ Lupus

□ Others:_____

Allergic/Immunologic & Blood/Lymphatic

□ Seasonal Allergies □ Hay Fever

□ Others:_____

Genitourinary

□ Genital Ulcers □ Discharge □ Kidney Stones

□ Blood in Urine □ Others:_____

Cardiovascular

□ Chest pain □ Congestive Heart Failure □ Irregular Rhythm

□ Pacemaker □ Others:_____

Head/Neck

□ Sinus Problems □ Post Nasal Drip □ Runny Nose

□ Dry Mouth □ Hearing Loss □ Others:_____

Constitutional & Integumentary

□ Fever □ Weight Loss □ Rash □ Skin Disease

□ Others:_____

Neurological Psychiatry & Musculoskeletal

□ Headache □ Migraines □ Paralysis Fever □ Joint Ache

□ Others:_____

Gastrointestinal

□ Vomiting □ Ulcers □ Diarrhea □ Bloody Stools

□ Others:_____

Respiratory

□ Cough □ Bronchitis □ Shortness of Breath □ Asthma

□ Emphysema □ COPD □ Others:_____

Social History

□ Current everyday smoker

□ Current some day smoker

□ Former smoker

□ Never smoked

□ Cigarettes

□ Cigars

□ Tobacco

□ Other

Please Circle and Fill in Blank Below:

Frequency:_____ Packs/Cigars

per Day/Week/Month

for _____ Months/Years

Medications:

□ No Medications

By Mouth (Please List):	**Eye Drops (Please List):**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
Drug Allergies (Please List):	
_____	
_____	
_____	
_____	
_____	
_____	
_____	
Surgeries (Please List):	**Eye Surgeries (Please List):**
_____	_____ Which Eye (Right/Left)
_____	_____ Which Eye (Right/Left)
_____	_____ Which Eye (Right/Left)
_____	_____ Which Eye (Right/Left)
_____	_____ Which Eye (Right/Left)
_____	_____ Which Eye (Right/Left)
_____	_____ Which Eye (Right/Left)

Additional Information:_____

_____

_____

_____

_____

_____