UAB EYE CARE
The University of Alabama at Birmingham

The Gift of Sight

Patient Application

Patient Information

					Date of Birth	Today's Date	
Patient Name (First, Middle, Last)	Suffix (Jr.,Sr.)	Salutation (Mr.,Ms.)	Social Security #	Birth State	Sex	Age	
Address (Home, Billing Address, Office/Business - circle)		City, State , Zip		Country United States			
Home Phone	Cell Phone	Work Phone / Ext	Email Address	Preferred Communication (Cell, Email)			
Special needs							
Primary Language	Marital Status	Maiden Name	Mother's Maiden Name				
Gender Identity (Male, Female, Male-to-female transsexual, Female-to-male transsexual)	Sexual Orientation (Straight, Bisexual, Homosexual, Other, Don't Know)						
Race	Race 2	Ethnicity	Ethnicity 2				
Employer	Occupation						

Responsible Party Information

Responsible Party's Name (Salutation, First, Middle, Last)	Date of Birth	Home Phone	Cell Phone	Work Phone / Ext	
Address (Street, City, State, ZIP)	Email Address	Social Security #	Gender		

Primary Insurance

Insured's Name	Date of Birth	ID Number
Insurance Company Name		Insurance Co. Phone
Insurance Company Address		
Group Name	Group Number	

Secondary Insurance

Insured's Name	Date of Birth	ID Number
Insurance Company Name		Insurance Co. Phone
Insurance Company Address		
Group Name	Group Number	

Monthly income $

Are you currently on food stamps?

Referrals - Shelters and Organizations only

Firm/Organization/Name	Phone	Address	Contact Person

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PATIENT HISTORY FORM

NAME: Birthdate: _____/_____/_____

Last First M. I.

Reason for today's clinic visit:

Please list any concerns you have about your eyes or vision:

Last Eye Exam: Dr. or location

Last Physical Exam: Dr. or location

CURRENT MEDICATIONS

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug **Dose (include strength & number of pills per day)**

1.
2.
3.
4.
5.
6.
7.
8.

Drug allergies: ❑ No ❑ Yes To what?

PAST MEDICAL HISTORY

Do you now or have you ever had:

❑ Diabetes
❑ High blood pressure
❑ High cholesterol
❑ Stroke
❑ Heart problems
❑ Cancer (type)_____
❑ Arthritis
❑ Thyroid problems
❑ Liver Problems
❑ Kidney Problems
❑ Cataracts
❑ Glaucoma
❑ Macular Degeneration
❑ Crossed Eyes/Strabismus
❑ Contact Lens Wear
❑ Eye Sx
❑ Eye Injury

Family Ocular Medical Hx:

❑ Diabetes
❑ Hypertension
❑ Stroke
❑ Heart

❑ Cataracts
❑ Glaucoma
❑ Macular Degeneration
❑ Strabismus

Any other patient/family general medical or ocular conditions (please list):

Do you drink alcohol? Yes ❑ No ❑	Do you use tobacco? Yes ❑ No ❑	Are you pregnant? Yes ❑ No ❑
Servings per week	If yes, how much?	Are you nursing? Yes ❑ No ❑

Do your hobbies or work put you at risk of an eye injury?

Do you have problems in the following areas?

General Health	Yes ❑ No ❑	Genital/Urinary	Yes ❑ No ❑	Blood or Lymphatic	Yes ❑ No ❑
Ears/Nose/Throat	Yes ❑ No ❑	Skin	Yes ❑ No ❑	Allergies/Immunology	Yes ❑ No ❑
Cardiovascular	Yes ❑ No ❑	Musculoskeletal	Yes ❑ No ❑	Endocrine	Yes ❑ No ❑
Respiratory	Yes ❑ No ❑	Neurological	Yes ❑ No ❑	Psychiatric	Yes ❑ No ❑
Gastrointestinal	Yes ❑ No ❑				

Attending (Initials):

UAB Eye Care

PATIENT:

AUTHORIZATIONS - PLEASE READ CAREFULLY

SERVICES AND FEES: I hereby consent to the examination and treatment that the provider feels is necessary for rendering good vision care. I understand that some services I receive at UAB Eye Care may be provided by qualified optometric interns in training, under the direct supervision of a fully degreed and licensed optometrist or other physician who will repeat key parts of the examination. I understand that the services I receive will only be performed when felt necessary and that some of these services may not be covered by my insurance. I understand I will be responsible for payment in full for all such services not covered by my insurance, that they may be considered lawful debt and promise to pay said fees including the cost of collection, attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama or any other state.

PERMISSION TO FILE INSURANCE CLAIMS AND FOR DIRECT PAYMENT OF INSURANCE BENEFITS: I authorize UAB Eye Care to file claims to my insurance provider on my behalf. I understand I can revoke this authorization at any time by providing UAB Eye Care with a written statement indicating that I revoke this authorization.

PERMISSION FOR DIRECT PAYMENT OF INSURANCE BENEFITS: I authorize my insurance provider to make payments on my behalf directly to UAB Eye Care. I understand I can revoke this authorization at any time by providing UAB Eye Care with a written statement indicating that I revoke this authorization.

PERMISSION TO RELEASE RECORDS TO OTHER HEALTHCARE PROVIDERS: I authorize UAB Eye Care to release records information regarding my care to other healthcare providers involved in my medical care. I understand I can revoke this authorization at any time by providing UAB Eye Care with a written statement indicating that I revoke this authorization.

PERMISSION TO USE ANONYMOUS MEDICAL INFORMATION IN HEALTHCARE TRAINING: I authorize UAB Eye Care to, when indicated, to make use of information from my medical records (including images of medical conditions) for the purposes of medical education. I understand that information used in this manner will not identify me by name and that I can revoke this authorization at any time by providing UAB Eye Care with a written statement stating such.

NOTICE OF PRIVACY PRACTICES (HIPAA): I understand that UAB School of Optometry and its affiliated clinics may share my health information for treatment, billing, and healthcare operations. I acknowledge that I have been given a copy of the UAB Eye Care Notice of Health Information Practices that describes how my health information is used and shared. I understand that UAB School of Optometry and its affiliated clinics have the right to change this notice at any time. I may obtain a current copy by contacting the UAB School of Optometry or any of its affiliated clinics.

My signature below constitutes my acknowledgment that I have been provided with a copy of the Notice of Health Information Practices.

_____

Signature of Patient (or Legal Representative) Date

If signed by legal representative, relationship to patient: _____

MEDIA RELEASE FORM

Date: 11/7/2023 through 12/1/23	Shoot Location: Western Health Center
Project: Gift of Sight	Photographer/Producer: TBD

AUTHORIZATION AND RELEASE

The University of Alabama at Birmingham (hereinafter "UAB") produces informative materials in various media formats for use as educational materials for the general public in the areas of research, patient care, and other areas of interest.

To accomplish this important goal of UAB, UAB requests persons to authorize it to utilize their name, likeness, voice, and/or performance, whether by motion picture, photograph, or quoted statements.

In the interest of furthering the above purpose, the undersigned knowingly and willingly agrees to be bound by this authorization and release and agrees as follows:

A. To authorize UAB to record my name, likeness, voice, and/or performance by any means of recordation, in particular, but without limitation, photograph, motion picture, and/or videotape; and

B. To authorize UAB to use my name, likeness, voice, and/or performance in any means of printed or Web publication or electronic broadcast; and

C. To not receive any form of consideration, in particular, but without limitation, royalties and/or payments from UAB or related entities, for said recordation and use by UAB of my name, likeness, voice, and/or performance in any means of publication; and

D. UAB has all rights, title, and interest to and the undersigned hereby assigns to UAB any rights of the undersigned to any recordation and any use of the recordation made pursuant to this authorization; further, UAB is authorized to control distribution, editing, and use of the said recordation locally, nationally, and internationally; and

E. To release and hold harmless UAB, UAB-related entities, and their agents, personnel, trustees, directors, officers, and employees against any and all claims for loss, damages, or injuries as a result of participating in the activities anticipated by this Agreement, in particular, but without limitation, the publication and the recordation of the name, likeness, voice, and/or performance of the undersigned.

The undersigned has read and voluntarily signed this authorization and release of liability and agrees to be bound by the terms and conditions herein.

Name (Print):

Signature:

Phone:

Address:

Authorization for Minor: