



Dr. Black's eye associates

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Rob Steller, O.D.

Dana Conway, O.D.
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(888) EYE-CARE
www.Have2020.com

REGISTRATION OF A MINOR PATIENT

For Office Use Only:
Date: _____
Location: _____
Doctor: _____

PATIENT INFORMATION

NAME: _____ RACE _____

ADDRESS: _____ ETHNICITY _____

CITY: _____ STATE/ZIP: _____ LANGUAGE _____

HOME PHONE: _____ EMAIL: _____

SOCIAL SECURITY NUMBER: _____ SEX: MALE FEMALE

DATE OF BIRTH: _____

REFERRING DR.: _____ FAMILY DR.: _____

EMERGENCY CONTACT

Please list a friend or relative who lives outside your home:

NAME	PHONE NUMBER	PATIENT'S RELATIONSHIP TO THIS CONTACT
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RESPONSIBLE PARENT INFORMATION

NAME: _____

ADDRESS: _____

CITY: _____ STATE/ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ EMAIL: _____

EMPLOYER'S NAME: _____

SOCIAL SECURITY NUMBER: _____ SEX: MALE FEMALE

DATE OF BIRTH: _____

EMAIL ADDRESS: _____

ACCOMPANYING PARENT INFORMATION

NAME: _____

ADDRESS: _____

CITY: _____ STATE/ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ EMAIL: _____

EMPLOYER'S NAME: _____

SOCIAL SECURITY NUMBER: _____ SEX: MALE FEMALE

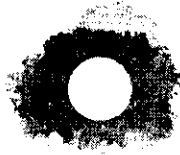
DATE OF BIRTH: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE CO.: _____

SUPPLEMENTAL INSURANCE CO.: _____

*Please give your insurance cards to us so we may make a copy for our records.
* Please make sure to sign and date the indicated areas on the reverse of this form.



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eye associates

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PERMISSION "AUTHORIZATION" FORM

302 W. 14th Street, Suite100
Jeffersonville, IN 47130
812.284.0660

1407 Spring Street
Jeffersonville, IN 47130
812.590.6220

1919 State Street, Suite 140
New Albany, IN 47150
812.948.4680

1350 S. Jackson Street
Salem, IN 47167
812.896.1717

215 E. Chestnut Street
Corydon, IN 47112
812.738.2278

441 Green Road
Madison, IN 47250
812.273.2020

1356 N. Gardner Street
Scottsburg, IN 47170
812.752.2020

1154 S. Ripley Estates Drive
Versailles, IN 47042
812.689.4721

732 High Street
Brandenburg, KY 40108
270.422.4241

1102 Lyndon Lane, Suite A
Louisville, KY 40222
502.426.0307

102 Diagnostic Drive
Frankfort, KY 40601
502.223.8258

Permission, "Authorized" form:

This authorization gives Eye Associates of Southern Indiana the permission to disclose your health information to the designated person of YOUR choice. It is a "blanket" authorization.

If you want your authorization to be more precise and/or to "whom" we may disclose it, please let us know.

For example:

- It gives us permission to give your testing results and/or appointment information to your spouse or designated family member or significant other, at no specified time, date, tests or appointments.
- It gives us permission to leave your results and/or information about an appointment on your answering machine at no specified date, time, or appointment.
- It give us permission to give your medication samples to this designated person at no specific time or date.

I, _____, give the staff and physicians at Eye Associates of Southern Indiana permission to disclose my protected health information for patient _____ to the following person (s):

My spouse _____

My children _____

Another family member or significant other _____

Date: _____

Your rights are explained on the "Notice of Privacy Practices" that you have been given. Any questions regarding this form may be directed to our Privacy Officer.

I authorize treatment of the person named on the front of this form. I have read the following "insurance claim filing" information and agree to pay all fees for such treatment if denied by my insurance carrier.

INSURANCE CLAIM FILING

MEDICARE: We will file all services to your Medicare. You will be responsible for any deductible, copayment, or non-covered services. We are a Medicare Provider. STATE MEDICAID: We will file all services to your State Medicaid. You will be responsible for any balance as determined by your Medicaid policy. We are a Medicaid Provider. ALL OTHER INSURANCE: We will file all services not covered by your carrier(s) as a courtesy to you. You will be responsible for any services not covered by your carrier that would not otherwise be adjusted due to any contract we may hold with your insurance carrier. Your responsibility may include, but will not be limited to copay, deductible, or charge derived due to an exclusion in your policy, such as routine eye exam coverage, or lack of a referral number if your policy requires one. I request that payment of authorized benefits be paid on my behalf to Eye Associates for any services furnished. I authorize any holder of medical information about me to release to the HCFA and its agents any information needed to determine these benefits payable for services.

Signature: _____ Date: _____

By signing below I give permission for Eye Associates, to access my pharmacy benefits data electronically through RxHub.

This consent will enable Eye Associates to:

- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

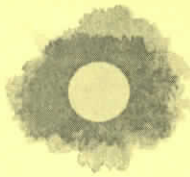
Signature: _____ Date: _____

Our practice, Eye Associates of Southern Indiana, participates with Nextgen Healthcare Information Systems, LLC and the Nextgen Patient Portal. To better communicate and allow you to manage your medical records we will create a login and password for you for your Patient Portal account. To do so, we accept the Terms and Conditions of the Nextgen Patient Portal website for you. When logging in for your first time, go to Have2020.com and select Patient Portal. The link provides you with the Terms and Conditions in its entirety. By signing this document, I agree to the Terms and Conditions of the Nextgen Patient Portal. By signing below, I ask Eye Associates to complete my enrollment and accept the Terms and Conditions on my behalf. I agree that I was offered a copy of the Terms and Conditions and that I may cancel this account at any time.

Signature: _____ Date: _____

I acknowledge and agree that Eye Associates and any affiliates, including collection and billing companies, may contact me by telephone, email or text message to any telephone number I provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify Eye Associates if I have given up ownership or control of any such telephone number.

Signature: _____ Date: _____



CHILD MEDICAL HISTORY

Patient Name: _____ Date: _____
 Pediatrician/Primary Care Physician _____ Pharmacy: _____
 Date of Birth: _____ Date of Last Eye Exam: _____
 Ethnicity: Hisp ___ Non Hisp ___ Preferred Language: English / Other _____ Race: _____

Eye Symptoms

	YES	NO		YES	NO		YES	NO		YES	NO
Eye Crossing	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>	Redness	<input type="checkbox"/>	<input type="checkbox"/>	Floaters or Spots	<input type="checkbox"/>	<input type="checkbox"/>
Eye Squinting	<input type="checkbox"/>	<input type="checkbox"/>	Tearing	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>
Eye Drifting	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>
Other _____											

Review of Systems - Please answer YES or NO for each question

	YES	NO		YES	NO		YES	NO		YES	NO
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding/Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Increased Urination	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	Heat Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Increased Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>

Please List medications you are currently taking (including eye medications)

Medication Name	Dosage	Medication Name	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is patient allergic to any medications? YES ___ NO ___ If YES _____

Ocular History

	YES	NO		YES	NO		YES	NO		YES	NO
Injury	<input type="checkbox"/>	<input type="checkbox"/>	Crossed Eye	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Laser Treatments	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery or Other Procedure _____											

Medical History

	YES	NO		YES	NO		YES	NO		YES	NO
Diabetic ___ yrs.	<input type="checkbox"/>	<input type="checkbox"/>	ENT/ Sinus	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Stroke	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Immune Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Surgery/Other Procedures _____											

Family History

Cataracts	<input type="checkbox"/>	Strabismus (Lazy Eye)	<input type="checkbox"/>	Near Sightedness	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Amblyopia (Poor vision)	<input type="checkbox"/>	Far Sightedness	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>
Other _____							

Social History

Does anyone smoke in the child's home? YES ___ NO ___ Does the child smoke? YES ___ NO ___
 Grade Level (If applicable) _____ Is the patient meeting developmental milestones? YES ___ NO ___
 Hobbies _____