Dr. Sherman Thurmond • Dr. Craig Wood • Dr. Rhonda Thurmond

Patient Information

First Name:________________________MI:__________Last Name: __________________________

SS#: __________-__________-__________ Birthdate: ________/________/________

Address: ____Apt/ Unit: ___________

City:______________________________ State: ______________Zip Code:_______________

Preferred Phone # (__________)__________-__________________ __home __cell __work

Email: ____

Occupation:__________________________ Employer: ____________________________________

If Minor

Parent/Guardian Name:___________________________ Relationship to Patient:_______________

SS#:__________-__________-__________ Birthdate: ________/________/________

Insurance Information

Policy Holder Name:______________________________ Relationship to Patient:_______________

SS#: __________-__________-__________ Birthdate: ________/________/________

Address (if different): ____

City:______________________________ State: ______________ Zip Code:_______________

Home (______)__________-______________Cell # (__________)__________-__________

How did you hear about our office?

__ Friend/Relative __Internet __Driving By __Advertisement __Other

Fee Schedule

Examination Charges are based on the professional time utilized for each particular procedure.
Our physicians require Retinal Photography to be done on all patients annually.
This will require an additional charge of $28.00 to your comprehensive examination.

Payment Policy

Physician Fee(s): All professional fees are due on the day services are rendered.
Contacts/ Eyeglasses: Payment is required before ordering.

Assignment of Health/ Vision Insurance Benefits:

I hereby assign all insurance benefits to Guilford Eye Center for services rendered in their office. This assignment includes benefits payable to Medicare, Medicaid and all other health/ vision insurance programs of which I am beneficiary. I authorize the release of all information from all sources necessary to secure payment for services rendered. The undersigned agrees to be responsible for any charges not covered by the above provided sources.

Patient Signature:____________________________________ Date: ______/______/________
(Guardian if minor)

Excellence in Eyecare for the Whole Family

1323 New Garden Road
Greensboro, NC 27410

PH 336 292 4516
FX 336 292 5706

office@guilfordeye.com
www.guilfordeye.com

Patient Medical History

Name:		DOB:	Age:	Date:
Race:	Sex:	Family Medical Doctor:		
Last Eye Exam :		Last Eye Doctor:		
Occupation:		Hobbies:		

Past Medical, Family, Social, Ocular History

Medical History/ Review Of Systems

Self		Family
	Arthritis	
	Blood Disease (anemia, Sickle Cell)	
	Ear, Nose, Throat (allergies)	
	GI Disease (ulcers, acid reflux, crohn's)	
	Thyroid Disease	
	Lung Disease (asthma, emphysema)	
	Heart Disease	
	Kidney, Bladder, Genital	
	Diabetes (sugar)	
	High Blood Pressure	
	Neurological Problems (brain, nerves)	
	Skin Disease	
	Mental (depression, Anxiety)	
	Cancer	
	Infectious Diseases (HIV, Hepatitis)	

Ocular History

Self		Family
	Cataracts	
	Glaucoma	
	Macular Degeneration	
	Blindness	
	Lazy Eye/ Eye Turn	
	Retinal Disorders	
	Eye Injuries	**N/A**
	Eye Surgeries	
	Other (List)	

Social History

Marital Status:
Do you live alone:
Smoke or use other forms of tobacco? If yes, how much/often?
Do you drink alcohol? If yes, how much/often?

Medications:

Drug Allergies:

	Patient Initials	Tech Initials	Dr. Initials	Date

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PHI means information about a patient, including but not limited to demographic information that may identify a patient that relates to the patient's past, present, or future, physical or mental health or condition, related healthcare services or payment for health care services.

Person(s) I authorize to receive my PHI:

Name	Relationship to Patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the patient and/or legal guardian, have received a copy of this office's Notice of Privacy Practices.

____

Print Patient Name

______________________________ ______________

Patient/Legal Guardian Signature **Date**

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

— Individual refused to sign
— Communications barriers prohibited
— An emergency situation prevented us from obtaining
— Other: (specify) ______________________________