Welcome to Our Office
Patient Information

Today's Date: _____

Last Name: _____

First Name: _____ **MI:** _____

Mailing Address: _____

City _____ **St** _____ **Zip** _____

Cell Phone: _____

Home/Work Phone: _____

Email: _____

Gender: M F **Date of Birth:** _____

Patient's SSN: _____

Employer: _____

Occupation: _____

Spouse's Name: _____

Spouse's SSN: _____ **DOB:** _____

How did you find out about our office?

- ❑ Another Patient: Who? _____
- ❑ Insurance List / Insurance Website
- ❑ Internet: Which Website? _____
- ❑ Yellow Pages
- ❑ Other _____

Lifestyle Questions

Are you planning on purchasing glasses today?

Yes No Maybe

Are you planning on getting your Annual Contact Lens Consultation today? Yes No Maybe

Do you wear Contact Lenses? Yes No

If so, what kind? _____

Do you still clean your lenses? Yes No

If so, solution used: _____

Rate your lenses when you 1st put them in:

Poor 1 2 3 4 5 Excellent

Rate your lenses when you take them out:

Poor 1 2 3 4 5 Excellent

Do you use rewetting drops? Yes No

If so, how often? _____

What specific problems or concerns do you have with your vision, eyes, glasses, or contacts?

_____

_____

_____

Date of Last Eye Exam: _____

Previous Eye Doctor: _____

Primary Physician: _____

Location: _____

Contact Phone if known: _____

Do you have a Specialist we need to send Notes?

Yes No

Who? _____

Contact phone: _____

Medications:

_____

_____

_____

_____

_____

_____

_____

Medications Allergic to:

_____

_____

_____

_____

_____

_____

_____

I ❑ do / ❑ do not wish to be dilated today.

Reason:

_____

_____

_____

_____

Signature

OVER PLEASE ⇨

Acknowledgement of Receipt of Privacy Practices (HIPPA)

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.
I acknowledge that I have received the Notice of Privacy Practices for Smoky Mountain Eye Care.

Patient Signature (Guardian if under 18) Date

I acknowledge that I have been informed of the Notice of Privacy Practices and have elected to NOT receive a copy.

Patient Signature (Guardian if under 18) Date

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. **Vision care plans** (such as VSP and EyeMed)
2. **Medical Insurance** (such as BCBS and Medicare)

- Vision care plans ONLY cover routine vision exams and may cover some materials (such as glasses or contacts). Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.
- Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
- We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we may bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.

I have read and agree with these policies.

Patient Signature (Guardian if under 18) Date

Insurance Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits and I authorize payment of these benefits directly to Smoky Mountain Eye Care on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in item 9 of the CMS-1500 Claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Patient Signature (Guardian if under 18) Date

Medical History

Name_____

CHECK THE SYMPTOMS AND/OR CONDITIONS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST.

CHECK "NEGATIVE" IF NONE APPLY TO YOU

CONSTITUTION
- □ Cancer
- □ Fatigue Syndrome
- □ Developmental Disabilities
- □ Negative

Other:_____

EAR NOSE AND THROAT
- □ Dry Mouth
- □ Hearing Loss
- □ Sinusitis
- □ Laryngitis
- □ Negative

Other:_____

NEUROLOGICAL
- □ Epilepsy
- □ Tumor
- □ Migraine
- □ Multiple Sclerosis
- □ Stroke/CVA
- □ Cerebral Palsy
- □ Negative

Other:_____

PSYCHIATRIC
- □ Depression
- □ Attention Deficit
- □ Bipolar Disorder
- □ Anxiety Disorder
- □ Negative

Other:_____

CARDIOVASCULAR
- □ Hypertension
- □ Heart Disease
- □ Congestive Heart Failure
- □ Vascular Disease
- □ Stroke/CVA
- □ Negative

Other:_____

RESPIRATORY
- □ Cigarette Smoker
- □ Sleep Apnea
- □ Emphysema
- □ Bronchitis
- □ COPD
- □ Asthma
- □ Negative

Other:_____

GASTROINTESTINAL (Stomach)
- □ Celiac Disease
- □ Colitis
- □ Crohn's Disease
- □ Acid Reflux
- □ Ulcer
- □ Negative

Other:_____

GENITOUTINARY
- □ Benign Prostate Hypertrophy
- □ Prostate Disease/ Cancer
- □ Chlamydia
- □ Nursing
- □ Pregnant
- □ STD-Herpetic
- □ Kidney Disease
- □ Negative

Other:_____

MUSCULOSKELETAL
- □ Osteoarthritis
- □ Muscular Dystrophy
- □ Osteoporosis
- □ Fibromyalgia
- □ Ankylosing Spondylitis
- □ Gout
- □ Negative

Other:_____

PLEASE FILL OUT THE OTHER SIDE.

INTEGUMENTARY

- □ Eczema
- □ Psoriasis
- □ Rosacea
- □ Herpes Zoster/ Shingles
- □ Herpes Simplex/ Cold Sores
- □ Negative

Other:_____

ENDOCRINE

- □ Hormonal Dysfunction
- □ Type 1 Diabetes
- □ Thyroid Dysfunction
- □ Type 2 Diabetes
- □ Negative

Other:_____

HEMATOLOGIC/ LYMPHATIC

- □ High Cholesterol
- □ Ulcer
- □ Anemia
- □ Large Volume Blood Loss
- □ Negative

Other:_____

PAST OCULAR HISTORY

- □ Cataracts
- □ Glaucoma
- □ Retinal Problems/ Macula
- □ Injury
- □ Surgery
- □ Lazy Eye
- □ Negative

Other:_____

FAMILY OCULAR HISTORY

Cataract: Father Mother Bro Sis Son Daughter

Macular Degeneration: Father Mother Bro Sis Son Daughter

Glaucoma: Father Mother Bro Sis Son Daughter

ALLERGIC/ IMMUNE

- □ Rheumatoid Arthritis
- □ Lupus
- □ Environmental Allergies
- □ Drug Allergies
- □ Sjogren's Syndrome
- □ Negative

Other:_____

FAMILY MEDICAL HISTORY

Cancer: Father Mother Bro Sis Son Daughter

Type 1 Diabetes: Father Mother Brother Sister Son Daughter

Type 2 Diabetes: Father Mother Brother Sister Son Daughter

Hypertension: Father Mother Bro Sis Son Daughter

Hyperthyroid: Father Mother Bro Sis Son Daughter

Hypothyroid: Father Mother Bro Sis Son Daughter

OTHER ALLERGIES

- □ Bee Stings

Environmental

- □ Animal Dander
- □ Dust
- □ Hay Fever
- □ Latex
- □ Ragweed

Food Allergies

- □ Dairy
- □ Nuts
- □ Shellfish

SOCIAL HISTORY

Drinking □ NO
□ YES
Socially or ___Drinks/day

Tobacco use □ NO
□ Yes

Smoker Status

- □ Never Smoker
- □ Former Smoker
- □ Current Some Day Smoker
- □ Current Every Day Smoker