Welcome to Our Office

Patient Information

Today's Date: _____

Last Name: _____

First Name: _____MI: _____

Mailing Address: _____

City _____St_____ Zip_____

Home Phone: _____

Work/ Day Phone: _____

Cell Phone: _____

Gender: M F Date of Birth: _____

Patient's SSN: _____

Employer: _____

Occupation: _____

Spouse's Name: _____

Spouse's SSN: _____DOB_____

Email: _____

Are you planning on purchasing glasses today?

Yes No Maybe

Are you planning on getting your annual contact lens evaluation today?

Yes No Maybe

What brand of contact lens do you currently wear?

_____

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: _____

Family Ocular History

Cataracts: Father Mother Brother Sister

Glaucoma: Father Mother Brother Sister

Macular Degeneration:

Father Mother Brother Sister

Past Ocular History

□ Cataracts

□ Glaucoma

□ Retinal Problems/ Macula

□ Injury

□ Surgery

□ Eye Turn

□ Negative

Family Medical History

Cancer: Father Mother Brother Sister

Type 1 Diabetes: Father Mother Brother Sister

Type 2 Diabetes: Father Mother Brother Sister

Hypertension: Father Mother Brother Sister

Hyperthyroid: Father Mother Brother Sister

Hypothyroid: Father Mother Brother Sister

Medications:

_____

_____

_____

_____

_____

_____

_____

Medications Allergic to:

_____

_____

_____

_____

_____

_____

Do you smoke? □ Yes □ No

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

Initials_____

Acknowledgement of Receipt of Privacy Practices (HIPPA)

In the course of providing services 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.

Please sign only one acknowledgement below:

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 the 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 problems or systemic health problems that have the potential for ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history, i.e., Diabetes.
- If you have both types of insurance, it may be necessary for us to bill some services to one plan and other services to another. We will use coordination of benefits to do this properly and 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 be released to the Centers for Medicare and Medicaid Services and its agents any information about me to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in item 9 of the CMS 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 What Type: _____
□ Developmental Disabilities
□ Negative

EAR NOSE AND THROAT
□ Dry Mouth
□ Hearing Loss
□ Negative

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

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

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

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

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

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

Blood / Lymphatic
□ Anemia
□ High Cholesterol
□ Large Volume Blood Loss
□ Negative

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

MUSCULOSKELETAL
□ Osteoarthritis
□ Muscular Dystrophy
□ Osteoporosis
□ Fibromyalgia
□ Gout
□ Negative

ALLERGIC/ IMMUNE
□ Rheumatoid Arthritis
□ Lupus
□ Environmental Allergies
□ Sjogren's Syndrome
□ Negative

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

Other Allergies
□ Dairy
□ Nuts
□ Shellfish