



PLEASE PRINT CLEARLY

Name: _____ DOB: _____ Age: _____ SS# _____

Home Ph# () _____ Work Ph#() _____ Cell Ph#() _____

Home Address: _____ City: _____

State: _____ Zip: _____ County: _____ E-mail Address: _____

Sex: M/ F Marital Status: S/ M / D/ W Employer & Occupation: _____

Spouse's Full Name: _____ DOB: _____ SS#: _____

Spouse's Employer: _____ Wk Ph# () _____

Other than spouse, who may we contact in case of emergency (*not living with you*)?

Name: _____ Relationship: _____ Phone: _____

Whom may we thank for referring you to Dr. Pilkinton? _____

If patient is under 21, please list:

Father's Name: _____ DOB: _____ SS#: _____

Address: _____ Employer: _____

Home Ph#() _____ Work Ph#() _____ Cell Ph#() _____

Mother's Name: _____ DOB: _____ SS# _____

Address: _____ Employer: _____

Home Ph#() _____ Work Ph#() _____ Cell Ph#() _____

Due to the Privacy Act, I hereby give permission, (**unless initialed "NO"**), for *Pilkinton Eye Center* to leave a voice mail or recorded message (NO _____), send postcards (NO _____), speak with spouse or family member concerning appointment (NO _____), medical condition (NO _____) or billing inquiries (NO _____).

Payment Terms: Payment is due at time of service for non-covered services, co-pays, deductibles and eye refractions. I acknowledge full responsibility of all services provided for me and agree to pay all expenses, including collection and attorney fees, necessary to collect the balance. I also agree to promptly notify *Pilkinton Eye Center* of any medical insurance carrier changes or coverage changes. Failure to do so may result in direct billing and monthly late charges. **** WE WILL FILE UP TO 2 MEDICAL INSURANCE PLANS. ****

Benefits: I hereby request that payment of Medicare, TennCare, Medigap, or other insurance benefits be made to *Pilkinton Eye Center* for any services. I authorize any holder of medical information about me to release to the Center for Medicaid/Medicare Center (CMS), or to my insurer, any information needed to determine these benefits.

PCP Approval: *Any patient who requires a primary care provider referral is responsible for obtaining his/her own referral authorization. Failure to do so will result in direct billing or rescheduling the appointment.*

Please check below how you will make payment today: *Cash* _____ *Check* _____ *Mastercard* _____ *Visa* _____

Patient Signature (or legal guardian if minor): _____ Date: _____

****Pilkinton Eye Center does not fit, dispense, or prescribe contact lenses. Pilkinton Eye Center does not participate in "vision plans".****

MEDICAL HISTORY

DATE _____

AGE _____

PATIENT'S NAME : _____ DOB: _____

Who is your primary care physician? _____ Phone: _____

Physician's Address: _____

Medical Illnesses (*Please circle illnesses you currently have or have had in the past*):

- | | | | |
|---------------------------|------------------|--------------------------|------------------------|
| Diabetes | Kidney Disease | Neurological Disease | Hay Fever |
| High Blood Pressure | Liver Disease | Thyroid Disease | Blood Disorder |
| Heart Disease | Lung Disease | Cancer | Auto-immune disease |
| Arthritis, Osteoarthritis | Stomach Problems | Asthma/Emphysema | Lupus |
| Rheumatoid Arthritis | Prostate Disease | Paralysis/Stroke/CVA/TIA | HIV/AIDS |
| | | | Polymyalgia Rheumatica |

What conditions are you currently being treated for? _____

List all previous surgeries: _____

FAMILY HISTORY

Do you or any blood relatives have any of the following conditions? (*Please indicate relationship*)

- | | |
|-----------------|----------------------------|
| Cataracts _____ | Macular Degeneration _____ |
| Glaucoma _____ | Retinal Detachment _____ |
| Diabetes _____ | Blindness _____ |
| | Crossed Eyes _____ |

OCULAR HISTORY

Do you currently have any of the following eye conditions? (*Circle all that apply*)

- | | | |
|---------------------------|------------------------------------|---------------------------|
| Glaucoma | Floaters (dark spots, spider webs) | Eye Infection |
| Cataract | Flashes of Light | History of Uveitis/Iritis |
| Retinal Disease | Curtains/Veils | Crossed/Wandering Eyes |
| Blurry Vision | Excessive Tearing/Discharge | Double Vision |
| Glare/Light Sensitivity | Excessive Itching | Amblyopia (Lazy Eye) |
| Distorted Vision or Halos | Sandy/Gritty Sensation | Drooping Eye Lid |
| Loss of Side Vision | Eye Pain/Burning | History of Eye Trauma |
| Sudden Vision Loss | Eye Strain or "Tired" Eyes | History of Eye Surgery |

Please describe prior eye surgeries or injuries: _____

List any eye medications or drops: _____ Last eye exam _____

Please bring current eyeglasses with you. What is the main reason for your visit today? _____
