

GENERAL INFORMATION

Patient's Full Name: _____ Social Security #: _____

Home Address: _____ City: _____

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

Home Phone:() _____ Work Phone:() _____ Cell Phone:() _____

Employer & Occupation: _____

Marital Status: S | M | D | W Sex: M | F Date of Birth: _____ Age: _____

Spouse's Full Name: _____ Work Phone: () _____

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

Name: _____ Relationship: _____ Phone: _____

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

If patient is under 21, please list:

Father's Name: _____ Social Security #: _____

Home Phone:() _____ Work Phone:() _____ Cell Phone:() _____

Mother's Name: _____ Social Security #: _____

Address: _____

Home Phone:() _____ Work Phone:() _____ Cell Phone:() _____

MEDICAL HISTORY

Who is your primary care physician? _____ Phone:() _____

Physician's Address: _____

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

- | | | | |
|---------------------|------------------|----------------------|------------------|
| Diabetes | Kidney Disease | Neurological Disease | Hay Fever |
| High Blood Pressure | Liver Disease | Thyroid Disease | Asthma/Emphysema |
| Heart Disease | Lung Disease | Cancer | Paralysis/Stroke |
| Arthritis | Stomach Problems | Blood Disorder | Lupus |

What conditions are you currently being treated for? _____

List all previous surgeries: _____

List all current prescription and OTC medications: _____

Allergies to medications (*name of medication & reaction*): _____

FAMILY HISTORY

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

Cataracts _____ Crossed Eyes _____

Glaucoma _____ Blindness _____

Retinal _____ Detachment Diabetes _____

OCULAR HISTORY

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

Glaucoma	Floaters (<i>dark spots, spider webs</i>)	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 (<i>Lazy Eye</i>)
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: _____

What is the main reason for your visit today? _____

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 unless other arrangements have been made.

If insurance is filed, I am responsible for co-pays, deductible, and eye refraction charges at that time.

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.

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:** _____