Pilkinton EYE CENTER

300 20th AVENUE NORTH, SUITE 504, NASHVILLE, TN 37203
P: 615-329-7890/F: 615-329-7892

PATIENT DEMOGRAPHICS

_____ _____ _____ _____ _____
(Title) (First Name) (Middle) (Last Name) (Suffix)

Marital Status: _____ Sex: Male/Female Social Security: _____

Date of Birth: _____ Age: _____ Driving License #: _____

COMMUNICATIONS

Address: _____ Zip: _____ City: _____ State: _____

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

Email: _____

PHYSICIANS & PHARMACY

Referring Physician: _____ Referring Physician Phone: _____

Primary Care Physician: _____ Primary Care Physician Phone: _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

Pharmacy Address: _____ Zip/City/State: _____

LANGUAGE, ETHNICITY, RACE, & OCCUPATION

Race: _____ Language: _____ Ethnicity: _____

Employer: _____ Occupation: _____

Employer Zip/City/State: _____

CONSENT TO RELEASE INFORMATION

To whom do you authorize access to your medical records?

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

EMERGENCY CONTACT, SPOUSE, & RESPONSIBLE PARTY/GUARANTOR

Emergency Contact (**not living w/you**): _____ Relationship: _____ Phone: _____

Spouse: _____ Spouse Social Security: _____

Spouse Date of Birth: _____ Spouse Phone: _____

Responsible Party/Guarantor (if not yourself): _____ Relationship: _____

Date of Birth: _____ Sex: Male/Female SSN: _____ Guarantor Phone: _____

Address: _____ Zip: _____ City: _____ State: _____

How did you hear about us? _____ **Today's Date:** _____

MEDICAL HISTORY

Ocular Health

Please mark any condition **you** presently have or have had in the past:

- ☐ Dry Eye
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Keratoconus
- ☐ Ocular Injury: _____
- ☐ Other - please explain: _____
  _____

Date of your last eye exam: _____ **Doctor/where:** _____

Do you wear glasses? *(YES or NO)* **Do you wear Contacts?** *(YES or NO)* **Brand & Rx:** _____

Family Ocular Health

Please mark any condition **your family members (blood relatives)** presently have or have had in the past and **whom**:

- ☐ Cataracts _____
- ☐ Dry Eye _____
- ☐ Glaucoma _____
- ☐ Keratoconus _____
- ☐ Macular Degeneration _____
- ☐ Keratoconus _____
- ☐ Other - please explain: _____

General Health

Please mark any condition **you** presently have or have had in the past:

- ☐ High Blood Pressure
- ☐ Heart Disease/Problems
- ☐ Arthritis *(**Circle** Rheumatoid or Osteo)*
- ☐ Lung Problems
- ☐ Stroke/CVA
- ☐ Thyroid Problems
- ☐ Diabetes *(**Circle** Type 1 or Type 2 and Insulin or Non-Insulin)*
- ☐ High Cholesterol
- ☐ Ulcers
- ☐ Cancer, Type: _____
- ☐ Other - please explain: _____

Family General Health

Please mark any condition **your family members (blood relatives)** presently have or have had in the past and **whom**:

- ☐ High Blood Pressure_____
- ☐ Heart Disease/Problems _____
- ☐ Arthritis _____
- ☐ Lung Problems _____
- ☐ Stroke/CVA _____
- ☐ Thyroid Problems _____
- ☐ Diabetes *(**Circle** Type 1 or Type 2 and Insulin or Non-Insulin)* _____
- ☐ High Cholesterol _____
- ☐ Ulcers _____
- ☐ Cancer, Type: _____
- ☐ Other - please explain: _____

Review of Systems

Please mark any conditions **you** presently have or have had in the past:

Allergic/Immunologic & Blood/Lymphatic:
☐ Seasonal Allergies ☐ Hay fever ☐ Hepatitis ☐ HIV/Aids ☐ MRSA ☐ Other _____

Cardiovascular:
☐ Chest Pain ☐ Congestive Heart Failure ☐ Irregular Rhythm ☐ Other _____

Constitutional & Integumentary:
☐ Fever ☐ Weight Loss ☐ Rash ☐ Skin Disease ☐ Other _____

Gastrointestinal:
☐ Vomiting ☐ Diarrhea ☐ Bloody Stools ☐ GERD/Acid Reflux ☐ Other _____

Genitourinary:
☐ Genital Ulcers ☐ Discharge ☐ Kidney Stones ☐ Blood in Urine ☐ Other _____

Head/Neck:
☐ Sinus Problems ☐ Post Nasal Drip ☐ Runny Nose ☐ Dry Mouth ☐ Hearing Loss
☐ Other _____

Neurological, Psychiatry & Musculoskeletal:
☐ Headache ☐ Migraines ☐ Paralysis ☐ Joint Ache ☐ Depression ☐ Anxiety ☐ Neuropathy
☐ Other _____

Respiratory:
☐ Cough ☐ Bronchitis ☐ Shortness of Breath ☐ Asthma ☐ Emphysema ☐ COPD
☐ Other _____

Social History

Do you smoke? **(YES or NO)** Type: _____ How much: _____ How often: _____

Have you ever smoked in the past? **(YES or NO)** How long have you smoked: _____

Do you drink alcohol? **(YES or NO)** Type: _____ Quantity: _____ How often: _____

Surgical History

Ocular (Eye) Surgeries/Procedures:

Please list any surgeries (LASIK, PRK, Cataract Surgery, Glaucoma Surgery, etc.) you have had, the date of surgery and the surgeon.

_____
_____
_____
_____

Bodily Surgeries/Procedures:

_____
_____
_____
_____

Medications

*****Do you or have you ever taken FLOMAX or any prostate medication? ☐YES ☐NO*****

Ocular (Eye) Medications:
Please list any **prescription or over-the-counter** eye drops/ocular supplements you currently use.

_____
_____
_____

Systemic Medications:
Please list any **prescription or over-the-counter** medications you currently take and the **milligrams/dose**.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies:

Medication, Food, or Latex – please list anything to which you are allergic.

_____
_____
_____
_____
_____
_____

☐**No Known Drug Allergies**

What is the main reason for your visit today?

_____

Are you experiencing:

☐Glare/Light Sensitivity ☐Distorted Vision or Halos ☐Difficulty driving due to Vision ☐Blurry Vision

☐Loss of Side Vision ☐Sudden Vision Loss ☐Floaters (dark spots, spider webs) ☐Flashes of Light

☐Curtains/Veils ☐Excessive Tearing/Discharge ☐Excessive Itching ☐Sandy/Gritty Sensation

☐Eye Pain/Burning ☐ Eye Strain/Tired Eyes ☐Eye Infection ☐History of Uveitis/Iritis

☐Double Vision ☐Amblyopia (Lazy Eye) ☐Drooping Eye Lid ☐History of Eye Trauma

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FINANCIAL AGREEMENT

Payment Terms:

Pilkinton Eye Center participates with most medical insurance plans. If there are questions about the patient's insurance policy or benefit details, please talk with the medical insurance provider before his/her appointment. It is each patient's responsibility to be familiar with his/her health plan.

Payment is due at the time of service for non-insured services, co-pays, deductibles, and eye refractions. Please call the patient's insurance provider for details such as co-pays and deductibles before your visit.

We will file up to two medical insurance plans. Please know that failure to bring insurance cards to each appointment may result in additional out-of-pocket expenses or appointment rescheduling.

Providing incorrect insurance information may result in direct billing to the patient.

Pilkinton Eye Center does not participate with vision plans.

We do not fit, dispense, or prescribe contact lenses. If the patient chooses to wear contact lenses, we will refer him/her to an optometrist who can assist in those services.

Some insurance plans, such as HealthSpring, require a referral from the Primary Care Doctor. It is the patient's responsibility to obtain this referral. Failure to obtain a referral will result in additional out-of-pocket expenses or appointment rescheduling.

Past due accounts will be collected in full before future appointments are made. Questions about the patient's account should be directed to our Billing Department at (615)329-7890.

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. I acknowledge that failure to do so may result in direct billing and monthly late fees.

I hereby request that payment of Medicare, 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 Medicare (CMS), or to my insurer, any information needed to determine these benefits.

Patient Name: _____

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

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HIPAA PATIENT CONSENT FORM

In response to the misuse of Personal Health Information, the *Department of Health and Human Services* has established a **Privacy Rule** to insure that your Personal Health Information is kept private. This rule was also established in order to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient in order to carry out treatment, payment, or other health care operations.

We want you to know that we respect the privacy of your personal medical records and will take all reasonable measures to secure and protect your privacy. When necessary we will provide the minimum necessary information to only those we feel are in need of your Personal Health Information in order to provide health care that is in your best interest.

We support your full access to your medical records. You should be aware that we may have indirect treatment relationships with you that include but are not limited to laboratories, pharmacies, and other medical offices. As such, we may need to disclose your Personal Health Information for purposes of treatment, payment and/or health care operations. These outside entities do not necessarily need to obtain your consent for this communication.

You have the right to refuse to consent to the use of disclosure of your Personal Health Information. This refusal must be made in writing. Under the HIPAA law, we have the right to refuse to treat you if you choose to refuse disclosure of your Personal Health Information. If you give consent to disclose your Personal Health Information, by signing this document, you can at some future time request to refuse future disclosures of your Personal Health Information. This refusal must be made in writing. However, you may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have received a copy of our Patient Privacy Policy. You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Please speak with our administrative staff if you have objections to this consent.

Please list any individual with whom we may discuss your Personal Health Information below (i.e. spouse, family member, friend, etc.):

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Patient Name: _____

Patient Signature: _____ **Date:** _____