*Date*_____ **Eye Centers of Tennessee** *P#*_____

Name_____ SS#_____

Address_____City_____State_____Zip_____

Home phone (____)_____Preferred#☐ Work (___)_____

Cell phone (___)_____ Preferred#☐ Email Address_____

Date of birth_____ Age_____ ☐ Male ☐ Female

Marital status ☐ Single ☐ Married ☐ Widowed

Employer_____Occupation_____

If retired, former occupation _____

Friend or relative Not living with you _____ Phone(___)_____

Spouse/Guardian/Parent Name _____**Spouse/Guardian/Parent SS#** _____

Spouse/Guardian/Parent employer _____**Spouse/Guardian/Parent DOB** _____

Responsible party if other than self _____ Phone ( ) _____

Address_____SS#_____DOB _____

What is the name of your Primary Care Physician?_____ City_____

Insurance:

☐Medicare ☐Aetna ☐VSP
☐United Health Care ☐Cigna ☐EyeMed
☐Blue Cross/Blue Shield ☐Humana ☐ March Vision
☐TennCare Select/Blue Care ☐Amerigroup ☐/Superior Vision

Referred By:

☐Physician (M.D.) _____
☐Optometrist (O.D/)_____

☐HealthSpring ☐ Davis Vision ☐ Other Insurance_____ Pharmacy_____

One Time Signature Authorization

Payment for all medical services is the responsibility of the patient and is expected at the time of service. There is a $15 service charge for all returned checks. We will bill your insurance in case of surgery.

I request that payment of authorized Medicare and/or other insurance benefits be made either to me or on my behalf to Eye Centers of Tennessee as indicated on the claim form for any services furnished me by them. I authorize the release of any medical information about me to the Health Care Financing Administration and/or insurance company(s) and their agents as necessary to process my claim. I also agree to be responsible for any deductions, co-insurance or disallowance of payments by my insurers.

You are responsible for any copays and the $30 Refraction Fee (glasses RX) if your insurance does not cover it, on the day of your visit.

I herby acknowledge that I was offered a copy of ECOTN's HIPPA Privacy Policy.

Signature of patient or responsible party_____
(DO NOT WRITE IN THIS SPACE↓)

PATIENT MEDICAL HISTORY– REVIEW ALL CATAGORIES

Name:_____ Date of Birth:_____

Primary Care Physician:_____ Pharmacy:_____

Who performed your most recent eye exam?_____ When?_____

OCULAR DISEASES:

- □ **NONE**
- □ Cataract
- □ Diabetic Retinopathy
- □ Dry Eyes
- □ Glaucoma
- □ Lazy Eye/ Eye Turn
- □ Macular Degeneration
- □ Retinal Detachment

PREVIOUS EYE SURGERIES:

- □ **NONE**
- □ Cataract
- □ Eye Injections
- □ LASIK, PRK, RK, or CK
- □ Eyelid surgery
- □ YAG Laser Surgery
- □ Retina Laser Surgery
- □ Glaucoma Surgery

LIST ALL PREVIOUS SURGERIES:

- □ **NONE**
- □ Appendectomy
- □ Back Surgery
- □ Cesarean Section
- □ D & C
- □ Gallbladder
- □ Heart surgery
- □ Hernia Repair
- □ Hip Replacement
- □ Hysterectomy
- □ Knee Surgery
- □ Mastectomy
- □ Pacemaker
- □ Tubal Ligation
- □ Tonsillectomy
- □ Thyroid Surgery

SYSTEMIC CONDITIONS: □ **NONE**

- □ Acid Reflux
- □ Allergies
- □ Anxiety
- □ Arthritis
- □ Cancer
- □ COPD
- □ Lupus
- □ Hearing Loss
- □ Heart Attack
- □ Hernia
- □ High Blood Pressure
- □ High Cholesterol
- □ Graves Disease
- □ Migraine
- □ Multiple Sclerosis
- □ Stroke
- □ Thyroid Disease
- □ AIDS/HIV
- □ Hepatitis A, B or C
- □ Staph/MRSA
- □ Nursing/Pregnant
- □ Diabetes— Type I or II
- □ Rheumatoid Arthritis (RA)
- □ Taking or Have Taken **Flomax (tamsulosin)**
- □ Taking **Plaquenil (hydroxychloroquine)**
- □ Taking **Amiodarone**
- □ Taking **Prednisone**
- □_____

LIST ALL MEDICATIONS THAT YOU ARE CURRENLTY TAKING (OR ATTACH A LIST) INCLUDING EYE DROPS AND NON-PRESCRIPTION

□ **NONE**

_____

_____

_____

_____

LIST ALL ALLERGIES TO MEDICATIONS: □ **NONE**

_____

_____

_____

FAMLY MEDICAL HISTORY: □ **NONE**

- □ Cancer Mother/Father/Grandmother/Grandfather/Sister/Brother
- □ Diabetes Mother/Father/Grandmother/Grandfather/Sister/Brother
- □ Glaucoma Mother/Father/Grandmother/Grandfather/Sister/Brother
- □ Lazy Eye/Eye Turn Mother/Father/Grandmother/Grandfather/Sister/Brother
- □ Macular Degeneration Mother/Father/Grandmother/Grandfather/Sister/Brother
- □ Heart Disease Mother/Father/Grandmother/Grandfather/Sister/Brother

SOCIAL HISTORY: Do you drink alcohol? YES / NO Do you smoke? YES / NO FORMER