Welcome To Our Office

FAMILY EYECARE AND THERAPY CENTER

629 Broad Street
Elizabethton, TN 37643
www.elizabethtoneyecare.com

NAME ______________________ ______ ____________________________ DATE ________________
First MI LAST

MAILING ADDRESS __________________________________ CITY ______________ STATE ________ ZIP ________

HOME PHONE ____________________ WORK PHONE ____________________ CELL ______________________

E-MAIL ____ IF NO E-MAIL, PLEASE CHECK AND INITIAL ________

BIRTH DATE ________________ AGE _________ SEX: [ ] MALE [ ] FEMALE SOC. SEC. # ____________________

OCCUPATION ________________________________ EMPLOYER ____________________________________

ETHNICITY: ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ HISPANIC ☐ NATIVE ☐ WHITE ☐ OTHER ☐ DECLINE TO SPECIFY

PRIMARY CARE PHYSICIAN ____ PHONE ______________

PARENTS / SPOUSE _______________________________________ PARENT / SPOUSE'S SOC. SEC. # ______________

EMERGENCY CONTACT (OTHER THAN HOME NUMBER) ____________________________________ PHONE ___________

WHO REFERRED YOU TO OUR OFFICE: PATIENT _____________________________ DOCTOR ___________________

PERSON RESPONSIBLE FOR PAYMENT _____________________________________ RELATIONSHIP ______________

HOME PHONE __________________ CELL PHONE __________________ SOC. SEC. # ________________________

DOB __________ EMPLOYER ______________________________ WORK PHONE ___________________________

ADDRESS (IF DIFFERENT FROM ABOVE) ____

IS THERE LEGAL GUARDIANSHIP DOCUMENTATION OF WHICH OUR OFFICE NEEDS A COPY? YES __________ NO __________

HAVE YOU EVER WORN GLASSES? _____ YES _____ NO DO YOU WEAR GLASSES NOW? _____ YES _____ NO

HAVE YOU EVER WORN CONTACT LENSES? _____ YES _____ NO DO YOU WEAR CONTACT LENSES NOW? _____ YES _____ NO

PAYMENT IN FULL IS DUE AT THE TIME SERVICES ARE RENDERED

ACKNOWLEDGMENT OF PRIVACY POLICY AND DISCLOSURE OF PATIENT INFORMATION

I acknowledge that I have been given the opportunity to review the Privacy Policy and can obtain a copy upon my request. I acknowledge this practice discloses information regarding my treatment to other healthcare professionals and insurance companies, as needed for treatment and for payment for treatment. If information is requested by persons other than healthcare professionals and insurance companies, this practice will only disclose medical and or vision treatment to the authorized person's names below. It is my responsibility to inform this office of any changes to this information.

I give my permission for Family EyeCare Center PLLC, to disclose information regarding treatment to the following person(s):

(1)______________________________ **Relationship**____________________________

(1)______________________________ **Relationship**____________________________

MEDICARE INSURANCE ASSIGNMENT AND RELEASE

I request payment of authorized Medicare and Medigap benefits be made on my behalf to Family EyeCare Center, PLLC, for any covered services and/or materials furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand Medicare will not cover any services determined as routine or screening. I also understand that I will be financially responsible for any charges for non-covered services and/or materials.

My signature indicates I agree to the aformentioned statements. The above assignments will remain in effect until revoked by me in writing. A photocopy of these assignments is to be considered as valid as the original.

FINANCIAL POLICY AND INSURANCE

I hereby authorize payment directly to Family EyeCare Center, PLLC, for all insurance benefits for any services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I also understand that depending on the services rendered, my medical insurance may be billed instead of my vision insurance. All co-payments, co-insurance, and deductions are due at time of service. I am aware that not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services they will not cover. Any service not covered is my responsibility. Family EyeCare Center, PLLC, reserves the right to charge interest and monthly re-billing charges as provided by state law on any past due balances. I also understand and agree that if I fail to pay my balance in full, my account will be turned over to a collection agency. If this action becomes necessary, I will be obliged to pay all costs of collection, including collection agency fees, court costs, and attorney's fees in addition to the balance owed on the account.

Signed: ____ **Date:**______________

(Patient or Guarantor)

MEDICAL HISTORY

OCULAR HISTORY: DO YOU HAVE NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING EYE CONDITIONS?

YES	NO		YES	NO	
[ ]	[ ]	EYE INJURY ______	[ ]	[ ]	GLAUCOMA
[ ]	[ ]	EYE OPERATION ______	[ ]	[ ]	RETINAL TEARS OR DETACHMENTS
[ ]	[ ]	BLINDNESS	[ ]	[ ]	MACULAR DEGENERATION
[ ]	[ ]	DRY EYES	[ ]	[ ]	FREQUENT EYE INFECTIONS
[ ]	[ ]	CROSSED EYES	[ ]	[ ]	EXCESSIVE TEARING OR DISCHARGE
[ ]	[ ]	LAZY EYE / AMBLYOPIA	[ ]	[ ]	CATARACTS
[ ]	[ ]	FLASHES / FLOATERS (circle)	[ ]	[ ]	OTHER ______

MEDICAL HISTORY: DO YOU HAVE NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

YES	NO		YES	NO	
[ ]	[ ]	ALLERGIES / SINUS	[ ]	[ ]	IMMUNE SYSTEM DISORDER ______
[ ]	[ ]	HIGH BLOOD PRESSURE	[ ]	[ ]	SKIN PROBLEMS ______
[ ]	[ ]	HEART DISEASE ______	[ ]	[ ]	CANCER - type ______
[ ]	[ ]	ENDOCRINE - circle: THYROID DIABETES, OTHER ______	[ ]	[ ]	NEUROLOGICAL ______
			[ ]	[ ]	HEADACHE
[ ]	[ ]	HEPATITIS - circle: A B C D E	[ ]	[ ]	SEIZURES
[ ]	[ ]	STOMACH / INTESTINES ______	[ ]	[ ]	PSYCHOLOGICAL - circle: DEPRESSION, ANXIETY OTHER ______
[ ]	[ ]	KIDNEY DISEASE / URINARY DISORDER (circle)			
[ ]	[ ]	BLOOD DISORDER ______	[ ]	[ ]	RESPIRATORY - circle: ASTHMA, BRONCHITIS, COPD, OTHER ______
[ ]	[ ]	MUSCLE / SKELETAL / JOINT PROBLEMS circle: ARTHRITIS, OTHER ______	[ ]	[ ]	SURGERIES ______
			[ ]	[ ]	OTHER ______

PLEASE LIST ANY MEDICATIONS OR TREATMENTS OF ANY KIND THAT YOU ARE CURRENTLY TAKING:

PLEASE LIST ANY KNOWN ALLERGIES OR SENSITIVITIES TO ANY MEDICATIONS:

IS THERE ANY FAMILY HISTORY OF THE FOLLOWING? LIST RELATIONSHIP (maternal, grandmother/grandfather, paternal grandmother/grandfather, aunt, uncle, father, mother, brother, sister, son, daughter, or distant relative)

YES	NO		RELATIONSHIP	YES	NO		RELATIONSHIP
[ ]	[ ]	BLINDNESS	______	[ ]	[ ]	CROSSED EYES	______
[ ]	[ ]	CATARACTS	______	[ ]	[ ]	LAZY EYE / AMBLYOPIA	______
[ ]	[ ]	GLAUCOMA	______	[ ]	[ ]	HIGH BLOOD PRESSURE	______
[ ]	[ ]	MACULAR DEGENERATION	______	[ ]	[ ]	DIABETES	______
[ ]	[ ]	RETINAL DISEASE	______	[ ]	[ ]	OTHER	______

SOCIAL HISTORY: *(This information is kept strictly confidential)*

TOBACCO USE: [ ] NEVER SMOKED
[ ] FORMER SMOKER
[ ] CURRENT SMOKER: HOW MANY PACKS PER DAY? ________ HOW MANY YEARS?________
[ ] CURRENT SMOKELESS TOBACCO

STOPPED SMOKING [ ] WITHIN LAST YEAR [ ] 1-2 YEARS [ ] 3-4 YEARS [ ] 4-5 YEARS [ ] 5+ YEARS

ALCOHOL USE: [ ] NONE [ ]SOCIAL USE [ ] 1-2 DRINKS PER DAY [ ] ALCOHOL DEPENDENCE
NARCOTIC / ILLEGAL DRUGS: [ ] NONE [ ]SOCIAL USE [ ] 1-2 DRINKS PER DAY [ ] ALCOHOL DEPENDENCE
SEXUALLY TRANSMITTED DISEASE: [ ] NONE [ ] YES [ ] HIV POSITIVE
BLOOD TRANSFUSIONS: [ ] NONE [ ] YES [ ] HIV POSITIVE