

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 _____	
BIRTHDATE	_____	AGE	_____ SEX: [] MALE [] FEMALE SOC. SEC. # _____
SCHOOL	_____	GRADE	_____ TEACHER _____
ETHNICITY:	<input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> HISPANIC <input type="checkbox"/> NATIVE <input type="checkbox"/> WHITE <input type="checkbox"/> OTHER <input type="checkbox"/> 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	_____

LEGAL GUARDIAN	_____	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 aforementioned 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?

<input type="checkbox"/>	<input type="checkbox"/>	EYE INJURY _____	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA
<input type="checkbox"/>	<input type="checkbox"/>	EYE OPERATION _____	<input type="checkbox"/>	<input type="checkbox"/>	RETINAL TEARS OR DETACHMENTS
<input type="checkbox"/>	<input type="checkbox"/>	BLINDNESS	<input type="checkbox"/>	<input type="checkbox"/>	MACULAR DEGENERATION
<input type="checkbox"/>	<input type="checkbox"/>	DRY EYES	<input type="checkbox"/>	<input type="checkbox"/>	FREQUENT EYE INFECTIONS
<input type="checkbox"/>	<input type="checkbox"/>	CROSSED EYES	<input type="checkbox"/>	<input type="checkbox"/>	EXCESSIVE TEARING OR DISCHARGE
<input type="checkbox"/>	<input type="checkbox"/>	LAZY EYE / AMBLYOPIA	<input type="checkbox"/>	<input type="checkbox"/>	CATARACTS
<input type="checkbox"/>	<input type="checkbox"/>	FLASHES / FLOATERS (circle)	<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____

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

<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES / SINUS	<input type="checkbox"/>	<input type="checkbox"/>	IMMUNE SYSTEM DISORDER _____
<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	SKIN PROBLEMS _____
<input type="checkbox"/>	<input type="checkbox"/>	HEART DISEASE _____	<input type="checkbox"/>	<input type="checkbox"/>	CANCER - type _____
<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE - circle: THYROID DIABETES, OTHER _____	<input type="checkbox"/>	<input type="checkbox"/>	NEUROLOGICAL _____
<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS - circle: A B C D E	<input type="checkbox"/>	<input type="checkbox"/>	HEADACHE
<input type="checkbox"/>	<input type="checkbox"/>	STOMACH / INTESTINES _____	<input type="checkbox"/>	<input type="checkbox"/>	SEIZURES
<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY DISEASE / URINARY DISORDER (circle)	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHOLOGICAL - circle: DEPRESSION, ANXIETY OTHER _____
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD DISORDER _____	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY - circle: ASTHMA, BRONCHITIS, COPD, OTHER _____
<input type="checkbox"/>	<input type="checkbox"/>	MUSCLE / SKELETAL / JOINT PROBLEMS circle: ARTHRITIS, OTHER _____	<input type="checkbox"/>	<input type="checkbox"/>	SURGERIES _____
			<input type="checkbox"/>	<input type="checkbox"/>	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
<input type="checkbox"/>	<input type="checkbox"/>	BLINDNESS	<input type="checkbox"/>	<input type="checkbox"/>	CROSSED EYES _____
<input type="checkbox"/>	<input type="checkbox"/>	CATARACTS	<input type="checkbox"/>	<input type="checkbox"/>	LAZY EYE / AMBLYOPIA _____
<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE _____
<input type="checkbox"/>	<input type="checkbox"/>	MACULAR DEGENERATION	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES _____
<input type="checkbox"/>	<input type="checkbox"/>	RETINAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____

DEVELOPMENTAL HISTORY:

PROBLEMS DURING PREGNANCY / BIRTH: NO YES if yes, please explain _____

GROSS MOTOR DELAYS: NO YES

SPEECH DELAYS: NO YES

ACADEMIC DELAYS: NO YES if yes, please explain _____

PAST / CURRENT THERAPIES: _____

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

HISTORY OF TOBACCO, ALCOHOL, OR NARCOTIC / ILLEGAL DRUG USE? NO YES Specify: _____

HISTORY OF SEXUALLY TRANSMITTED DISEASE? NO YES HIV POSITIVE

HISTORY OF BLOOD TRANSFUSION? NO YES HIV POSITIVE