Welcome! Medical Eye Exam Registration

Section 1: Registration Information

Patient Name_________________________________ (As printed on your insurance card)

Mobile Phone________________________________ (Prescriptions Refill Information, Glasses Pick Up Notification and Appointment Reminders will be securely texted to this number.)

Email _______________________________________ (Your access to your electronic health records will be connected to this email. Password resets will be sent to this email.)

Work Phone__________________________________

Date of Birth________________________________

Address_____________________________________

City ____________________________ **State of TN /** _________ **ZIP Code**___________________

Social Security (your insurance may not pay your claim without your SS#)_____________________

Gender ❑ Male ❑ Female ❑ Binary

Preferred Language ❑ English ❑ Spanish ❑ Other _______________

Ethnicity ❑ Non Hispanic or Latino ❑ Hispanic or Latino ❑ Other _______________

Race ❑ Black or African American ❑ American Indian/Alaska Native ❑ Asian
❑ Hawaiian/Pacific Islander ❑ White ❑ Other ____________________

Insurance Information

Subscriber's Name as it appears on your insurance card ______________________________

Subscriber's Birthdate ____

Subscriber's Relationship to Patient ____________________________________

Subscriber's Social Security # (if different from above)_______________________

Primary Insurance Company ____

ID Number ____________________ Group Number ________________________

Secondary Insurance Company ____

ID Number ______________________ Group Number ___________________________

Who can we thank for referring you to our office?______________________________________

Which family members have not seen an eye specialist for a comprehensive exam this year? (This does not include school screenings or pediatrician screenings, as these are not comprehensive examinations). Select all that apply

- ❑ Spouse / Partner
- ❑ School aged children
- ❑ Parents

How can we improve upon your visit today versus previous eye examinations? (select all that apply)

- ❑ Better understanding your condition and treatment
- ❑ Wait time
- ❑ Friendliness of staff
- ❑ More time with the doctor
- ❑ Problems with contact lenses
- ❑ Problems with glasses
- ❑ Other ____

The main way we use our eyes is for school / work and fun, so:

What do you do for fun? ____

What do you do for work or what grade are you in?____

Section 2: What brings you in today?

What specific problem(s) with your eyes would you like your doctor to treat today? (select all that apply)

- ❑ Yearly Diabetic Exam
- ❑ Yearly High Blood Pressure Exam
- ❑ Bi-Annual Lupus Exam / Arthritis / Auto-Immune Disease (Plaquenil or Methotrexate exam)
- ❑ Referred by your doctor /primary care provider for a medical eye exam
- ❑ Check the status of Cataracts
- ❑ Concerned about Glaucoma
- ❑ Concerned about Macular Degeneration = “age spots” in the back of the eye
- ❑ Dry Eye Disease = Ocular Surface Disease
- ❑ Need refills on your prescription eye medication(s)
- ❑ Accident / Injury ❑ Pain ❑ Redness ❑ Burning ❑ Watery ❑ Light sensitivity
- ❑ Swollen lid ❑ Painful bump on lid ❑ Non-painful bump on lid ❑ Blurry vision
- ❑ Flashes lights in your side vision ❑ Loss of your side vision ❑ Dots or spots moving in your vision
- ❑ Other ____________________________

Which eye(s) is (are) bothering you? ❑ Right ❑ Left ❑ Both

What do you put in your eyes? (select all that apply)

❑ Freshkote ❑ Xiidra ❑ Restasis ❑ Lumigan, Travatan or Latanoprost
❑ Alphagan or Brimonidine ❑ Timoptic or Timolol ❑ Vyzolta
❑ Brimonidine with Timolol in 1 bottle = Combigan ❑ Azopt or Trusopt = Dorzolamide
❑ Timolol with Dorzolamide in 1 bottle = Cosopt ❑ Over the counter drops for redness
❑ Red out drops: Name______________________ ❑ Moisturizing drops: Name____________________
❑ Allergy drops: Name_______________________ ❑ Other: Name ____________________________

What preventative treatments for your eyes do you do? (select all that apply)

❑ Take Tear Support Vitamins ❑ Take Retinal Support VItamins
❑ Use Blephadex lid cleanser pads ❑ Bruder Mask therapy for tear glands
❑ Wear UV protection sunglasses

Would you like to be measured for a new glasses prescription today? The reduced cost is $35.

❑ Yes ❑ No

How would you like to improve your glasses? (select all that apply)

❑ Better vision for far way distances like driving and watching television
❑ Reduced eye strain when working on the computer or digital devices
❑ New style frames
❑ Better UV & sun protection
❑ Less thick and heavy glasses
❑ Glare protection for working on a computer and riding in a car at night and in the rain
❑ No improvements needed

Do you experience eye strain when using a phone, computer or reading printed materials?

❑ Yes ❑ No

Section 3: Patient's Medical & Social History

Primary Care Provider:____

Pharmacy Name & Phone:____

Constitution

❑ Cancer ❑ Fatigue Syndrome ❑ Developmental Disabilities ❑ Autism
❑ Other ____ **❑ NONE**

Ear, Nose, & Throat

❑ Dry mouth ❑ Hearing Loss ❑ Sinusitis Laryngitis
❑ Other ____ **❑ NONE**

Neurological

❑ Epilepsy ❑ Tumor ❑ Migraine ❑ Multiple Sclerosis
❑ Alzheimer's Disease ❑ Cerebral Palsy ❑ Reduced Mental Function ❑ Dementia

- ❑ Other ______________________________ ❑ **NONE**

Psychiatric

- ❑ Depression ❑ Attention Deficit ❑ Bipolar Disorder ❑ Anxiety Disorder
- ❑ Other ______________________________ ❑ **NONE**

Cardiovascular

- ❑ High blood pressure ❑ Heart Disease ❑ Congestive heart failure
- ❑ Vascular Disease ❑ Stroke/CVA
- ❑ Other ______________________________ ❑ **NONE**

Respiratory

- ❑ Sleep Apnea ❑ Emphysema ❑ Chronic Bronchitis
- ❑ Chronic Obstruction ❑ Asthma
- ❑ Other ______________________________ ❑ **NONE**

Gastrointestinal (Stomach)

- ❑ Celiac disease ❑ Colitis ❑ Crohn's
- ❑ Acid Reflux ❑ Ulcer
- ❑ Other ______________________________ ❑ **NONE**

Genitourinary

- ❑ Pregnant ❑ Nursing
- ❑ Benign Prostate Hypertrophy ❑ Prostate disease/cancer
- ❑ Chlamydia ❑ STD Herpetic/Chlamydia
- ❑ Kidney Disease
- ❑ Other ______________________________ ❑ **NONE**

Musculoskeletal

- ❑ Osteoarthritis ❑ Muscular dystrophy ❑ Osteoporosis
- ❑ Arthritis ❑ Gout ❑ Ankylosing Spondylitis
- ❑ Other ______________________________ ❑ **NONE**

Skin Related Conditions

- ❑ Eczema ❑ Psoriasis ❑ Cold Sores
- ❑ Shingles (Herpes Zoster)
- ❑ Other ______________________________ ❑ **NONE**

Gland Related Conditions

- ❑ Hormonal Dysfunction ❑ Thyroid Dysfunction
- ❑ Diabetes w/ Insulin (Type1) ❑ Diabetes w/ Oral Meds (Type 2)
- ❑ Polycystic ovary syndrome
- ❑ Other ______________________________ ❑ **NONE**

Blood Related Conditions

- ❑ Large amount of blood loss ❑ High Cholesterol ❑ Ulcer ❑ Anemia
- ❑ Other ______________________________ ❑ **NONE**

Past Eye History

- ❑ Injury ❑ Glaucoma ❑ Cataracts ❑ Surgery ❑ Lazy Eye

❑ Other ____ ❑ **NONE**

Immune System

❑ Rheumatoid Arthritis ❑ Lupus ❑ Sjogen's Syndrome ❑ HIV Positive

❑ Other ____ ❑ **NONE**

Allergies

❑ Animal Dander ❑ Dust ❑ Hay Fever

❑ Latex ❑ Ragweed ❑ Bee Stings

Do you consume alcohol?

❑ No ❑ Yes ❑ Amount per Week:_______

Do you smoke or vape?

❑ Never Smoker ❑ Former Smoker ❑ Current Smoker ❑ Amount per Week:_______

List all prescription medications that you take (pills, creams, injections, other)

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____

____

____

List all vitamins / supplements that you take______________________________

____

List all medication that you are allergic to________________________________

____

Does anyone in your family (ONLY include parents, siblings, or children) have any of the following eye or medical conditions? (select all that apply)

❑ Cataracts ❑ Glaucoma ❑ Macular Degeneration ❑ Lazy Eyes

❑ Severe Nearsightedness ❑ Severe Farsightedness ❑ Crossed Eyes

❑ Retinal Detachment ❑ Dry Eye Disease ❑ Jumpy Eyes

❑ High Blood Pressure ❑ Diabetes ❑ Cancer

❑ Thyroid Disease ❑ Other:_____________ ❑ **None**

Section 4: Insights & Information (Terms of Service)

Healthcare reforms are requiring our practice to constantly change and meet the demands of both state and federal regulations. Many of these changes you will never know; however, there are some changes we must make that do affect you. Our complete list of "Insights & Information" (Terms of Service) is on our website: www.wteye.com detailing how our doctors and staff work to provide excellent patient care and service while at the same time being fair and respectful to all our patients. Additionally, this information reviews how we work to protect your privacy and reduce your health care cost by giving you complimentary access to our insurance advocates to process your insurance. Remember, that these days

insurance is helping more and more patients reduce their overall health care costs, but it does not eliminate all of your out of pocket expenses.

Listed here is a summary of the Terms of Service that you are agreeing to as a patient at West TN Eye:

- I understand that I acknowledge that I am financially responsible for all charges whether or not paid by insurance.
- I grant for myself (or my dependent) full authority for West Tennessee Eye doctors and their assigned assistants to administer and perform any and all medications, treatments, tests, electro-diagnostics, and diagnostic imaging as is necessary for my care. I understand that pupil dilation at all examinations is expected.
- I, the undersigned certify that I (or my dependent) have insurance coverage as indicated above and assign directly to West Tennessee Eye all insurance benefits, if any, otherwise payable to me for services rendered.
- Your vision insurance will be filed for general vision eye exams for glasses prescriptions that include the measurement for your glasses prescription (manifest refraction).
- Your medical insurance will be filed for your exam if you have medical issues related to the health of your eyes such as diabetes, high blood pressure, arthritis, irritated eyes, floaters or dots in your vision, cataracts, “pink eye”, or itchy eyes.
- If you have your insurance company make your glasses (Davis Vision, VSP, EyeMed) they will make your glasses in a lab outside of Memphis and you should expect them to return your glasses to our office in about 2-3 weeks.
- To avoid a no-show fee of up to $100, please extend the courtesy of cancelling your appointment 24-hour in advance to reschedule.
- Contact lens consultation fees, which range from $50-$100, are in addition to the cost of the routine vision exam and are due at the time of service.
- Your signature confirms that should a concern arise in any aspect of your care or engagement with West Tennessee Eye you agree to mediate any dispute.
- Children under 18 years of age need a parent or guardian present during their entire visit.
- All threats of violence or perceived threats of violence, harassment or perceived harassment will result in termination of all care at any of our locations.
- Your medical records are available online.
- West Tennessee Eye complies with all state and federal regulation and does not discriminate based on gender identification, race, religious belief, political options, disability, and sexual orientation; in summary all are welcome here!

Section 5: Privacy Protection & Authorizations

This authorization for release of protected health information is provided by West Tennessee Eye, PLC (the “Practice”). For information about how your medical information may be used or disclosed, please see the complete Patient Notice. You have the right to review the Notice before you decide to sign this form. The Notice is subject to change. You may request a copy of the Notice from the Privacy Officer of the Practice. The Notice is also posted at the Practice’s offices.

- YOU HAVE THE RIGHT TO INSPECT, COPY AND/OR AMEND INFORMATION TO BE USED OR DISCLOSED.
- YOU MAY REFUSE TO SIGN THIS FORM, HOWEVER IT MAY PREVENT US FROM PROVIDING ALL YOUR EYE CARE.
- YOUR TREATMENT IS NOT CONDITIONED ON A RELEASE OF INFORMATION. A COPY OF THIS FORM AND THE EXTENDED PRIVACY PROTECTION POLICY IS AVAILABLE UPON REQUEST.

MEDICAL RECORDS RELEASE

I authorize the Practice to release my complete medical record (this may contain treatment notes regarding radiology, pathology *including HIV test results and genetic testing information*, immunization, procedure(s), *alcohol and drug abuse records protected by Federal Confidentiality Rules 42 CFR Part 2*, and other common medical record documentation made by the physician, nurse or other ancillary personnel) for the entire time I was treated by the Practice to the following family members or friends who contact the Practice for purposes of providing them with information related to my treatment and/or payment obligations:

Emergency Contact Name____

Emergency Contact Phone_____________________________________

Primary Care Provider Name____

Primary Care Provider Phone__________________________________

Spouse / Partner / Family Member Name________________________________

Spouse / Partner / Family Member Phone___________________________

SPECIFIED MEDICAL RECORD RELEASE:

For example, for disclosure of specific limited information to a school official, your employer, etc

I authorize the Practice to release the following types of records:

❑ Medical Eye Exams ❑ Vision Eye Exams ❑ Only dates of exams

For services provided to me by the Practice during previous:

❑ Last 12 months ❑ Last 24 months ❑ Other:_______________

I authorize the Practice to release this information to the following person(s) :

Name____

❑ **Mailed** ____

____

❑ **Faxed** ____

I understand that I may withdraw my authorization in writing to the Privacy Officer of the Practice at any time, except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization that this statement will not expire. I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

I acknowledge and affirm that: 1) I have read or had read to me the contents of this document agree to Terms of Service 2) all information provided is accurate and complete 3) I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.

Patient's Representative's / Legal Guardian's Signature____

Name & relationship of patient's representative____

Patient Signature____