Welcome! Vision 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
❑ Friendliness of staff
❑ Problems with contact lenses
❑ Other _____
❑ Wait time
❑ More time with the doctor
❑ Problems with glasses

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?

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, digital devices or reading printed materials
❑ New style frames
❑ Better UV & sun protection
❑ Less thick and heavy glasses
❑ Glare & harmful Blue Light Protection when on phone, computer and riding in a car at night

What do you routinely (at least once every day) put in your eyes? (select all that apply)

❑ Red out drops: Name_____
❑ Allergy drops: Name_____
❑ Moisturizing drops: Name_____
❑ Other: Name _____

Do you normally find that blinking clears up your vision during the day? ❑ Yes ❑ No
Do you experience dry, burning or scratchy eyes most days? ❑ Yes ❑ No

Do you have any additional concerns about how you see or the health of your eyes?

_____

_____

If you wear contact lenses, please complete the following:

What is the name of the contact lenses you wear? _____

What cleaning solution do you use? _____

On average, how often do you throw your contact lenses in the trash and start a new fresh pair?

- ❑ Every Night
- ❑ About every 15 days
- ❑ About every 30-45 days
- ❑ About every 90 days
- ❑ More than 3 months
- ❑ Yearly

What time of the day do your contact lenses get uncomfortable and feels like you need to add moisturizing drops or just take them out?

- ❑ Lunch time (after 4-6 hours of wear)
- ❑ Dinner time (after 11-12 hours of wear)
- ❑ Bed time (after 15 hours of wear)

How is your vision in your contact lenses? (select all that apply)

- ❑ Blurry when watching TV and driving
- ❑ Blurry when look at your phone
- ❑ Blurry when look at your computer
- ❑ Vision is clear at all distances

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 (POS)
❑ 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)

_____

_____

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_____ Phone:_____

Primary Care Provider Name_____ Phone:_____

Spouse / Partner / Family Member Name_____ 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____