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.)

Alternate Phone_____ **Date of Birth** _____

Address_____**City** _____ **State** _____ **ZIP**_____

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

Gender ❑ Male ❑ Female ❑ Non-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 ❑ Caucasian ❑ Other _____

Section 2: Insurance Information

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

Subscriber's Birthdate _____

Subscriber's Relationship to Patient _____

Subscriber's Social Security Number _____

Primary Insurance Company _____

ID Number _____ Group Number _____

Secondary Insurance Company _____

ID Number _____ Group Number _____

Section 3: What brings you in today? Check 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 also known as 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 is bothering you? ❑ Right ❑ Left ❑ Both

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

- ❑ Oral Tear Support Supplements ❑ Oral Retina Support Supplements
- ❑ Blephadex lid cleanser pads ❑ Heat therapy mask for tear glands
- ❑ Wear UV protection sunglasses

Would you like to be measured for a new glasses prescription today? The reduced cost is $50.

❑ Yes ❑ No

If yes, 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 & tired eyes when using a phone, computer or reading printed materials?

❑ Yes ❑ No

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 insurance ❑ Problems with glasses
- ❑ Other _____

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

What do you do for fun? _____

What is your occupation? _____

Complete backside of all pages

Section 4: Patient's Medical & Social History: Check all that apply

Pharmacy Name & Phone:_____

Gland Related Conditions

❑ Diabetes ❑ Borderline Diabetes Age of Diabetes Diagnosis:_____
❑ Hormonal Dysfunction ❑ Thyroid Dysfunction ❑ Polycystic ovary syndrome (POS)
❑ Other _____ ❑ **NONE**

Cardiovascular

❑ High blood pressure ❑ Heart Disease ❑ Congestive heart failure
❑ Vascular Disease ❑ Stroke/CVA ❑ Peripheral Neuropathy
❑ Other _____ ❑ **NONE**

Constitution

❑ Cancer ❑Fatigue Syndrome ❑Developmental Disabilities / Reduced Mental Function
❑ Other _____ ❑ **NONE**

Ear, Nose, & Throat

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

Neurological

❑ Epilepsy ❑ Migraine ❑ Multiple Sclerosis ❑ Neuropathy
❑ Autism ❑ Alzheimer's Disease ❑ Cerebral Palsy ❑ Dementia
❑ Other _____ ❑ **NONE**

Psychiatric

❑ Depression ❑ ADHD / Attention Deficit ❑ Bipolar Disorder ❑ Anxiety
❑ Other _____ ❑ **NONE**

Respiratory

❑ Smoker ❑ Emphysema ❑ Chronic Bronchitis
❑ Sleep Apnea ❑ Asthma ❑ Chronic Obstruction
❑ Other _____ ❑ **NONE**

Gastrointestinal (Stomach)

❑ Celiac Disease ❑ Colitis ❑ Crohn's ❑ Acid Reflux ❑ Ulcer
❑ Other _____ ❑ **NONE**

Genitourinary

❑ Currently Pregnant ❑ Currently Nursing ❑ Prostate Disease ❑ Chlamydia
❑ Benign Prostate Hypertrophy ❑ Herpes ❑ Kidney Disease
❑ Other _____ ❑ **NONE**

Musculoskeletal

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

Skin Related Conditions

❑ Eczema ❑ Rosacea ❑ Psoriasis ❑ Cold Sores ❑ Shingles (Herpes Zoster)
❑ Other _____ ❑ **NONE**

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Blood Related Conditions

❑ High Cholesterol ❑ Large amount of blood loss ❑ Foot Ulcer ❑ Anemia

❑ Other _____ ❑ **NONE**

Immune System

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

❑ Other _____ ❑ **NONE**

Allergies

❑ Animal Dander ❑ Dust ❑ Hay Fever

❑ Latex ❑ Ragweed ❑ Bee Stings

❑ Other _____ ❑ **NONE**

Past Eye History

❑ Injury ❑ Glaucoma ❑ Cataracts ❑ Surgery ❑ Lazy Eye

❑ Other _____ ❑ **NONE**

Do you consume alcohol?

❑ No ❑ Yes = Most Days ❑ Yes = Socially

What is your smoking or vaping history?

❑ Never Smoked

❑ Current Smoker What age did you start smoking? _____

❑ Former Smoker What age did you start smoking? _____ What age did you stop?_____

List all prescription medications prescribed and over the counter (pills, creams, injections) ❑ NONE

_____

_____

List all vitamins and supplements that you take: ❑ NONE

_____

List all medication that you are allergic to: ❑ NONE

_____

Does anyone in your family (ONLY include parents, siblings, or children) have any of the following eye or medical conditions? ❑ None

❑ Cataracts ❑ Macular Degeneration ❑ Glaucoma ❑ Dry Eye Disease

❑ Severe Nearsightedness ❑ Severe Farsightedness ❑ Crossed Eyes ❑ Lazy Eyes

❑ Retinal Detachment ❑ High Blood Pressure ❑ Diabetes ❑ Thyroid Disease

Section 5: 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 & Conditions that you are agreeing to as a patient at West TN Eye:

- I understand and I acknowledge that I am financially responsible for all charges whether or not paid by insurance.

Complete backside of all pages

- 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 to be expected.
- I 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, watery, 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 canceling your appointment 36-hours in advance.
- Your appointments are rescheduled to our “first come, first serve” walk-in schedule if you do not confirm your appointment via phone, text or email at least 36-hours prior. This means you do not have a guaranteed appointment time which will extend your wait.
- Your signature confirms that should a concern arise from any aspect of your care or engagement with West Tennessee Eye you agree to mediate any dispute.
- Remote telehealth services are provided by our doctors.
- 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 and are accessible via our website using the email you have listed above.
- 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 6: HIPAA / Privacy Protection & Authorizations

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 when I was treated by the Practice to the following people who contact the Practice for purposes obtaining information related to my treatment and/or payment obligations:

Emergency Contact Name_____ Phone:_____

Primary Care Provider Name_____ Phone:_____

Spouse / Partner / Family Member Name_____ Phone:_____

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 PREVENT US FROM PROVIDING 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.

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 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.

Signature of Adult Patient _____ **Date**_____

Signature of Patient’s Parent
Legal Guardian’s or POA _____ **Date**_____

Name & relationship of patient’s parent, guardian or POA

_____

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