# 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**_______

**Circle all that apply:**

**Did you receive our confirmations:** Text Email Automated Call Personal Call

**Patient's Social Security Number:**________________________ (Not required if you are not filing insurance)

**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 or White ❑ Other ____________________

## Section 2: Insurance Information

☐ **Vision Insurance:** To help you receive the maximum benefits and avoid unexpected charges, bring ALL vision insurance cards you want billed for your vision exam, glasses and contact lenses?

☐ **Medical Insurance:** To ensure your medical eye care is billed correctly, bring all ALL medical and pharmacy insurance cards you want used for medical eye care (such as watery eyes, pink eye, eye injuries, diabetes, high blood pressure, cataracts, glaucoma, etc.)?

**NOTE: We have a new computer system and your old cards are no longer on file.**

☐ Provide Social Security Number associated with the insurance coverage:________________________
The SS number of the sponsor / policy holder / patient is NOT required if you are NOT filing insurance.
NOTE: Please call and update West TN Eye with your new insurance, if it changes before your next appointment. Your insurance needs pre-approval 48-hours before your next exam.

## Section 3: What brings you in today? Check all that apply

- ❑ Yearly **Diabetic Exam** medical eye exam
- ❑ Yearly **High Blood Pressure Exam** for the back of your eyes
- ❑ Bi-Annual **Lupus or Arthritis Exam / 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 use?** (Check all that apply)

❑ Oral Tear Support Omegas Supplements ❑ Oral Macular Support Supplements / AREDS 2

❑ Blephadex Lid Cleanser Wipes ❑ Heat therapy mask for tear glands ❑ Wear UV protecting sunglasses

**Would you like to be measured for a new glasses prescription today?** The cost is $53. ❑ Yes ❑ No

**Would you like to return using your vision insurance to be measured for new glasses?** ❑ Yes ❑ No

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

- ❑ Better vision for far away 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

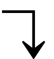
❑ Problems with insurance ❑ Problems with glasses

❑ 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 all 6 pages.** Next visit, save time and register online before your appointment 

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

**Gland Related Conditions**

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

**Cardiovascular** (Heart and blood vessels)

❑ High blood pressure ❑ Heart Disease ❑ Congestive heart failure
❑ Vascular Disease ❑ Stroke/CVA ❑ Peripheral Neuropathy (nerve damage & pain)
❑ Other ______________________________________________ ❑ **NONE**

**Constitution** (Groups of mental and physical conditions)

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

**Ear, Nose, & Throat**

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

**Neurological** (Brain & Nerve Conditions)

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

**Psychiatric** (Behavioral Health)

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

**Respiratory** (Breathing Conditions)

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

**Gastrointestinal** (Stomach)

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

**Genitourinary**

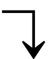
❑ Currently Pregnant ❑ Currently Nursing ❑ Prostate Disease ❑ Chlamydia
❑ Benign Prostate Hypertrophy ❑ Herpes ❑ Kidney Disease
❑ Other ______________________________________________ ❑ **NONE**

**Musculoskeletal** (Muscles & Bones)

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

**Skin Related Conditions**

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

**Complete all 6 pages.** Next visit, save time and register online before your appointment 

**Blood Related Conditions**

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

❑ Other ________________________________________ ❑ **NONE**

**Immune System**

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

❑ Other ________________________________________ ❑ **NONE**

**Allergies**

❑ 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? _____ Amount per day:__________

❑ 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**

❑ **CHECK BOX** if you provided an updated list to the front desk upon arrival and skip this section.

____________________________________________________________

____________________________________________________________

**List all vitamins and supplements that you take:** ❑ **NONE**

____________________________________________________________

**List all medication that you are allergic to:** ❑ **NONE**

____________________________________________________________

**Does anyone in your family have any of the following eye or medical conditions?** ❑ **None**

(ONLY include parents, siblings, or children)

| | | | |
|---|---|---|---|
| ❑ Cataracts | ❑ Macular Degeneration | ❑ Glaucoma | ❑ Dry Eye Disease |
| ❑ Severe Nearsightedness | ❑ Severe Farsightedness | ❑ Crossed Eyes | ❑ Lazy Eyes |
| ❑ Retinal Detachment | ❑ High Blood Pressure | ❑ Diabetes | ❑ Thyroid Disease |

**Complete all 6 pages.** Next visit, save time and register online before your appointment

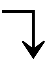
## **Section 5: Insights & Information** (Terms of Service)

Healthcare reforms require our practice to continually adapt to both state and federal regulations. Many of these changes happen behind the scenes, but some will affect you directly. This outlines how our doctors and staff deliver high-quality care, protect your privacy, promote fairness, and help reduce your healthcare costs—most notably through complimentary access to our insurance advocates. A digital copy of our **"Insights & Information" & Notice of Privacy Practices** can always be found at [www.wteye.com](www.wteye.com).

**NOTE: Insurance coverage helps reduce out-of-pocket costs but does not usually eliminate all costs**.

**By signing below, I acknowledge, I understand and I consent as Patient, Parent/Guardian of a minor dependent, or Power of Attorney (POA) for a patient at West TN Eye:**

- The doctors and staff at West TN Eye to administer medications, treatments, tests, electrodiagnostic procedures, ultrasounds, lab testing, and imaging necessary for my care or that of my dependent.
- Pupil dilation is a standard and is expected to be a part of every exam. If I arrive with legal driving vision while wearing glasses, I will typically be legal to drive after dilation. However, if I am concerned, I will bring a driver.
- I certify that I (or my dependent) have insurance coverage as provided and assign benefits directly to West TN Eye. Insurance is filed as a courtesy. West TN Eye makes no guarantee of benefit coverage or payment. I understand that: 1) I am financially responsible for all charges, whether or not paid by insurance.
  2) I acknowledge that "Prior authorization of benefits is not a guarantee of payment" from my insurance company.
  3) I may choose to pay by cash, check, or credit card, then file my own insurance for reimbursement.
- **Vision Insurance** covers routine vision exams for glasses prescriptions, including manifest refraction- the "which is better 1 or 2" test.
  Contact lens consultations are not included in a vision exam and range from $50–$250 depending on complexity.
  TennCare does not pay for contact lens services. By TN law, contact lenses services cannot occur on the same day as the vision exam for patients with TennCare insurance.
- **Medical Insurance** is used for eye-related medical issues such as: Diabetes, high blood pressure, arthritis, dry or watery eyes, floaters, cataracts, "pink eye", itchy eyes, etc. A refraction during a medical visit adds $53, which is not covered by medical insurance and must be paid at the time of services.
- **Eyewear Orders & Cancellations:** If I choose to have my insurance, Davis Vision, VSP, or EyeMed make my glasses, they will use a lab outside of Memphis, typically taking 2–3 weeks. Glasses made with West TN Eye are made in our Memphis lab and are finished much quicker. All orders are transmitted electronically upon payment, making them non-cancelable once processed.
- **Appointments & Attendance:** No-Show Fee of up to $150, depending on service type, applies if I do not cancel at least 48 hours (2 days) in advance of my appointment's start time. If I do not confirm my appointment by phone, text, or email at least 48 hours prior, my appointment will be cancelled. If I come to my appointment that I did not confirm, I will be placed in the first-come, first-served line, resulting in extended wait times or be rescheduled to another day.
- I will accompany children/minors under 18 years during the entire examination. Otherwise the child will not be seen without an authorized adult proxy present who was pre-authorized in writing to substitute for the guardian.
- **Digital Records, Communication & Telehealth:** My medical records, prescriptions, appointments, and payments are securely stored and accessible via my patient portal. Setup instructions are provided at [www.wteye.com](www.wteye.com)
  using my email address listed above or by written handout. I consent for West TN Eye to use digital "talk to text" technology to improve documentation, communication and reduce wait times. Additionally, I understand WTE utilizes video surveillance as a safety measure.Telehealth services are available and provided by our doctors when appropriate.
- Should a concern or dispute arise from any aspect of my care or engagement with West TN Eye, I agree to mediate any disputes based on Federal Arbitration Act (9 U.S.C., Secs. 1-16).

**Complete all 6 pages.** Next visit, save time and register online before your appointment 

- **Expectations & Patient Conduct:** Threats, harassment, foul language, or disrespectful behavior—whether real or perceived—will result in termination of care at all West TN Eye locations along with family members. Patients dismissed must obtain a new provider within 30 days.
- **Respectful Conduct:** I understand that West TN Eye, PLC expressly prohibits discrimination and all forms of harassment based on race, color, religion, sex, pregnancy, national origin, age, disability, sexual orientation, military or veteran status, gender identity, religious beliefs, or any status protected by law. Even if I personally disagree with this non-discrimination policy, I acknowledge that West TN Eye is a professional healthcare environment, not a forum for public debate. I agree to remain respectful in my words and actions, to refrain from inappropriate comments or conduct, and to maintain a calm and courteous demeanor during my visit. I understand that failure to do so may result in the termination and transfer of my care outside of West TN Eye.

## Section 6: YOUR PRIVACY — A HIPAA Overview

We respect and protect your health information. Here are the most important things to know:

**Our Responsibility:**

- Keep your information private and secure
- Notify you if there is a data breach
- Follow this notice

**Your Rights:**

- Get a copy of your medical records
- Request how we contact you
- Discuss any concerns with us
- Ask us to correct your information
- Ask us to limit certain sharing
- File a complaint if you have a concern
- Know who has received your data

**We Use Your Information To:**

- Treat you and improve your care
- Bill your insurance
- Run our practice and follow the law
- We may also share information for public health, safety, or legal reasons when required.

**Our Communications:**

We will contact you about:

- Appointments
- Glasses or contacts ready for pickup
- Medication refills and care updates
- Billing or account information

We will contact you by:

- Phone calls
- Text messages
- Email

You can opt out anytime by contacting us or replying “STOP” to texts.

Message and data rates may apply

Let us know if you have special requests

**Questions or Concerns:**

Contact our Privacy Officer: **Jerry D. Redmond, Esq.** wte.operations@wteye.com

*Full Notice of Privacy Practices available at* wteye.com *and upon request.*

**Your Important Contacts:**

**Primary Care Provider Name**_______________________________ Phone:_______________

**Spouse / Partner / Family Member Name**_______________________________ Phone:_______________

**Emergency Contact Name**_______________________________ Phone:_______________

**Pharmacy**_______________________________ Phone:_______________

**Your Agreement:**

I acknowledge and agree to the information provided above:

**Signature of Adult Patient** _______________________________ Date_______________

**Signature of Patient’s Parent**
Legal Guardians or POA _______________________________ Date_______________

Printed Name of Patient’s Parent
Legal Guardians or POA _______________________________ Relationship_______________

Medical Exam Registration History 04.2026

**Complete all 6 pages.** Next visit, save time and register online before your appointment