Welcome

Thank you for choosing our practice for your vision and eyecare needs. Please complete the front and back of this form so that we may better serve you. If you have any questions or concerns, do not hesitate to ask for assistance. Telephone Number (423) 283-7300 (Please Print)

Patient Information

Date _____ [] Mr. [] Mrs. [] Ms. [] Dr.

Patient Name _____

Preferred Name _____

Address _____

_____

City State Zip

Sex [] Male [] Female Birthdate _____

[] Married [] Single [] Widowed [] Divorced

Social Security Number _____

Home Telephone Number _____

Cellular Telephone Number _____

Work Telephone Number _____

Email Address _____

Occupation _____

Employer _____

Spouse or Parents Name _____

Spouse's Phone Number _____

Whom may we thank for your referral? _____

_____

Person to contact in case of emergency:

_____

Home Phone _____ Work Phone _____

Insurance Information

Who is responsible for this account? _____

Relationship to Patient _____

Birthdate _____ SS Number _____

Medical Insurance _____

Member ID/SS# _____

Group # _____

Do you have additional insurance? [] Yes [] No

Medical Insurance _____

Member ID/SS# _____

Group # _____

Relationship to Patient _____

Vision Insurance _____

Member ID/SS# _____

Group # _____

Relationship to Patient _____

ASSIGNMENT AND RELEASE I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Keith Family Vision Clinic, PC all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance**. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party **Date**

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ or Keith Family Vision Clinic, PC for any services furnished me by the doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency shown. In Medicare assigned cases, the physician, or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature of Beneficiary Date

Medical History Questionnaire And Consent To Treat Patient Form

Medications

List any medications you are currently taking: _____

_____

_____

_____

_____

Primary Care Doctor _____

Last Medical Exam _____

Allergies

List any allergies to medications: _____

_____

_____

_____

_____

Pharmacy Name _____

Telephone Number _____

Eye Health History

Last Eye Doctor _____
Last Eye Exam _____
Do you wear glasses? [] Yes [] No
Do you wear contact lenses? [] Yes [] No
If yes, what type: [] Hard [] Soft [] Disposable [] Other
If no, would you like to wear contact lenses? [] Yes [] No
Have you had Laser Vision correction? [] Yes [] No
If no, are you interested in Laser Vision Correction? [] Yes [] No
List any eye problems you have had: _____
_____
_____
List any eyedrops you are currently using: _____
_____

Family History

Please note any family history (parents, siblings, grandparents, and/or children, living or deceased) for the following conditions:

	Relationship to Patient
Cataract	_____
Glaucoma	_____
Macular Degeneration	_____
Retinal Detachment	_____
Diabetes	_____
Heart Attack	_____
Stroke	_____
High Blood Pressure	_____
Cancer	_____
Arthritis	_____
Other	_____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you use illegal drugs? [] Yes [] No If yes, type/amount/how long _____
Do you drink alcohol? [] Yes [] No If yes, type/amount/how long _____
Do you use tobacco products? [] Yes [] No If yes, type/amount/how long _____

Review of Systems

Do you currently or have you ever had any problems in the following areas: (If yes, please explain and list medications)

SYSTEM	YES	NO	?	EXPLAIN / LIST MEDICATION
CONSTITUTIONAL (Fever, Weight Gain/Loss)	[]	[]	[]	_____
EYES				
Blurred Vision/Loss of Vision	[]	[]	[]	_____
Poor Night Vision	[]	[]	[]	_____
Problems With Glare	[]	[]	[]	_____
Dryness/Burning	[]	[]	[]	_____
Mucous Discharge	[]	[]	[]	_____
Redness	[]	[]	[]	_____
Itching	[]	[]	[]	_____
Excessive Tearing/Watering	[]	[]	[]	_____
Eye Pain	[]	[]	[]	_____
Light Sensitivity	[]	[]	[]	_____
Flashes of Light/Floaters	[]	[]	[]	_____
EARS, NOSE, THROAT, & MOUTH				
Sinus	[]	[]	[]	_____
Hearing Problem	[]	[]	[]	_____
RESPIRATORY				
Asthma	[]	[]	[]	_____
Bronchitis	[]	[]	[]	_____
Emphysema	[]	[]	[]	_____
GASTROINTESTINAL (Diarrhea/ Constipation)	[]	[]	[]	_____
GENITOURINARY (Genitals, Kidneys, Bladder)	[]	[]	[]	_____
CARDIOVASCULAR / VASCULAR				
Diabetes	[]	[]	[]	_____
High Blood Pressure	[]	[]	[]	_____
Stroke	[]	[]	[]	_____
Heart Attack	[]	[]	[]	_____
MUSCLES / JOINTS / BONES				
Arthritis/Joint Pain	[]	[]	[]	_____
NEUROLOGICAL				
Migraines/Headaches	[]	[]	[]	_____
HEMATOLOGIC / LYMPHATIC (Anemia)	[]	[]	[]	_____
INTEGUMENTARY (Skin)	[]	[]	[]	_____
ALLERGIC / IMMUNOLOGIC	[]	[]	[]	_____
ENDOCRINE (Thyroid/Other Glands)	[]	[]	[]	_____
PSYCHIATRIC	[]	[]	[]	_____
OTHER	[]	[]	[]	_____

By signing this form, I consent to treatment for myself and/or on behalf of the Minor for which this information pertains. I give permission for the doctor/s/ to examine, diagnose, and initiate treatment as deemed appropriate. I further attest that I am the Parent or Legal Guardian of the Minor and have the authority to authorize care and treatment.

_____
Patient/Parent or Guardian Today's Date