

Bartlett Vision Clinic

3114 Kirby Whitten Parkway

Bartlett, TN 38134

Phone: 1-901-377-9588

Step 1	PATIENT REGISTRATION
Patient	_____
Address	_____
_____	_____
City	State Zip
Home Phone Number	_____
Cell Number	_____
Work Number	_____
Email Address	_____
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate _____ Age _____
Social Security number	_____
Occupation	_____
Employer	_____
Employer Address	_____
Date of Last Vision Exam	_____
Date of Last Med. Exam	_____
Do you wear glasses? <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, how old is your present pair of lenses? _____
Do you wear contacts? <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, how old is your present pair of lenses? _____
Type of contacts: Rigid, Soft, Extended Wear, Other	Are they comfortable? <input type="checkbox"/> Y <input type="checkbox"/> N

Step 2	INSURANCE
Who is responsible for this account?	_____
Relationship to Patient	_____
Birthdate	SS# _____
Insurance Company	_____
Group number	_____
Is patient covered by additional insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Subscriber Name	_____
Birthdate	SS# _____
Relationship to Patient	_____
Insurance Company	_____
Group number	_____
ASSIGNMENT AND RELEASE	
I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Bartlett Vision Clinic 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 Signature	Date _____
MEDICARE AUTHORIZATION	
I request that payment of authorized Medicare benefits be made on my behalf to Bartlett Vision Clinic for services furnished me by Bartlett Vision Clinic. I authorize any holder of medical information about me to release to the Division of Medicare and Medicaid Services and its agents any information needed to determine those 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 of 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 non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.	
Beneficiary Signature	Date _____

How did you find our office? _____

Step 3	MEDICAL HISTORY QUESTIONNAIRE
PAST PERSONAL HISTORY	
MEDICATIONS	PRIMARY CARE PHYSICIAN INFORMATION
▪ _____	Name _____
▪ _____	Address _____
▪ _____	Phone Number _____ FAX _____
Drug Allergies _____	
Describe all major illnesses, injuries, and surgeries:	

How would you prefer for us to contact you? By phone _____, Cell _____, work _____, or email _____. Please check all that apply.

FAMILY HISTORY

Please note any family member with the following diseases/conditions; M-mother F-father S-sibling GP-grandparent

	YES	NO		YES	NO
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Dz.	<input type="checkbox"/>	<input type="checkbox"/>
			Macular Deg.	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY

Health Habits
Check which substances you use and the consumption.

	YES	NO
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Quantity:	_____	
Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Quantity:	_____	
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>
Quantity:	_____	

Social History
Please indicate hobbies and interest:

	YES	NO
Computers	<input type="checkbox"/>	<input type="checkbox"/>
Fishing	<input type="checkbox"/>	<input type="checkbox"/>
Golfing	<input type="checkbox"/>	<input type="checkbox"/>
Hunting	<input type="checkbox"/>	<input type="checkbox"/>
Music	<input type="checkbox"/>	<input type="checkbox"/>
Reading	<input type="checkbox"/>	<input type="checkbox"/>
Other	_____	

REVIEW OF SYSTEMS

Check the symptoms and/or conditions you currently have or have had in the past.

	YES	NO	UNKNOWN		YES	NO	UNKNOWN
EYES				GASTROINTESTINAL (Stomach)			
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY			
Distorted Vision (Halos)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	INTEGUMENTARY (Skin)			
Flashes/Floppers in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC/HEMATOLOGIC			
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NEUROLOGIC			
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Styes or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BONE/JOINT/MUSCLE				Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint/Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC			
CANCER				Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	REPRODUCTIVE			
Prostate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nursing Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CONSTITUTIONAL				RESPIRATORY			
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain/Loss (Sudden)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE				Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EAR, NOSE, AND THROAT				Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR			
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry Mouth/Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 to care and treatment.

Patient/Parent or Guardian

Today's Date

Doctor's Signature

Review Date

**Bartlett Vision Clinic
3114 Kirby Whitten Rd.
Bartlett, TN 38134**

Contact Person: Medical Records Clerk

**ACKNOWLEDGEMENT OF PRIVACY POLICY AND
PRACTICES**

I understand that in an attempt to protect the privacy of my identifiable health information, Bartlett Vision Clinic has established a privacy policy and guidelines for privacy practices in their office. This information details the use and/ or disclosure of information contained in my personal medical/optometric records kept for the purpose of diagnosis, treatment, payment, and healthcare operations In accordance with HIPPA regulations, a copy of Bartlett Vision Clinic Privacy Policy and Practices has been made available to me while in the office today. Should I choose to have a personal copy; one will be given to me at no charge.

() I have read, understand and acknowledge the Privacy Policy and Practices of Bartlett Vision Clinic.

() I have elected not to read the Privacy Policy and Practices of Bartlett Vision Clinic.

() A copy of the Bartlett Vision Clinic Policy and Practices was given to me today.

I give permission for Dr. Crowe and her staff to discuss my examination information

with _____

Phone _____

Signature: _____

Wellness Retinal Imaging Consent Form

As part of your eye exam, Dr. Crowe recommends a special diagnostic procedure called Wellness Retinal Imaging. This procedure consists of capturing an image of the back part (retina) of your eye. This is not an x-ray or ultrasound procedure; and nothing will touch your eye. We are simply taking a digital photo.

This permanent record is very valuable in assessing the current health of your eye and for safeguarding the health of specific structures of your eye such as the retina, optic nerve, macula, and blood vessels. It will also serve as an initial point from which to compare, as we follow your health in subsequent years. This Retinal Imaging can even detect abnormalities that can't be seen with direct view of your retina. Many systemic diseases such as hypertension, diabetes, and high cholesterol can also be detected by evaluating the retina with this procedure.

There will be a \$ 39.00 fee for this screening. Depending on your diagnosis, this test may or may not be covered under your medical insurance or Medicare. Retinal Screening images are also not covered under most vision plans. If Retinal defects are discovered and extensive photos are required, the charge will be \$75.00 which can be filed under your medical insurance. This office will advise you of your coverage.

_____ Yes, I want to have retinal photos taken of my eye for documentation.

_____ No, I do not wish to have retinal photos taken.

Patient Signature: _____

Date: _____