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 ___M ___F Birthdate _____ Age _____

Social Security number _____

Occupation _____

Employer _____

Employer Address _____

Date of Last Vision Exam _____

Date of Last Med. Exam _____

Do you wear glasses? ___ Y ___N If yes, how old is your present pair of lenses? _____

Do you wear contacts? ___Y___N If yes, how old is your present pair of lenses? _____

Type of contacts: Rigid, Soft, Extended Wear, Other

Are they comfortable? _____Y_____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? ☐ Yes ☐ 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

- _____ _____
- _____ _____
- _____ _____

Drug Allergies _____

PRIMARY CARE PHYSICIAN INFORMATION

Name _____

Address _____

_____

Phone Number _____ FAX _____

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.

Step 3

MEDICAL HISTORY QUESTIONNAIRE (cont.)

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	___	☐	☐	Diabetes	___	☐	☐
Blindness	___	☐	☐	Glaucoma	___	☐	☐
Cancer	___	☐	☐	Heart Disease	___	☐	☐
Cataracts	___	☐	☐	Hypertension	___	☐	☐
Crossed Eyes	___	☐	☐	Retinal Dz.	___	☐	☐
				Macular Deg.	___	☐	☐

SOCIAL HISTORY

Health Habits

Check which substances you use and the consumption.

	YES	NO
Alcohol	☐	☐
Quantity: _____		
Drugs	☐	☐
Quantity: _____		
Tobacco	☐	☐
Quantity: _____		

Social History

Please indicate hobbies and interest:

	YES	NO
Computers	☐	☐
Fishing	☐	☐
Golfing	☐	☐
Hunting	☐	☐
Music	☐	☐
Reading	☐	☐

Other_____

REVIEW OF SYSTEMS

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

	YES	NO	UNKNOWN
EYES			
Blurred Vision	☐	☐	☐
Burning	☐	☐	☐
Cataracts	☐	☐	☐
Crossed Eyes	☐	☐	☐
Distorted Vision (Halos)	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Glaucoma	☐	☐	☐
Infection of Eye or Lid	☐	☐	☐
Itching	☐	☐	☐
Lazy Eye	☐	☐	☐
Loss of Vision	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Retinal Disease	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Styes or Chalazion	☐	☐	☐
BONE/JOINT/MUSCLE			
Arthritis	☐	☐	☐
Joint/Muscle Pain	☐	☐	☐
Polio	☐	☐	☐
CANCER			
Breast	☐	☐	☐
Lung	☐	☐	☐
Prostate	☐	☐	☐
Skin	☐	☐	☐
CONSTITUTIONAL			
Fever	☐	☐	☐
Weight Gain/Loss (Sudden)	☐	☐	☐
ENDOCRINE			
Thyroid Abnormalities	☐	☐	☐
EAR, NOSE, AND THROAT			
Allergies	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Mouth/Throat	☐	☐	☐
Hay Fever	☐	☐	☐
Runny Nose	☐	☐	☐
Sinus Congestion	☐	☐	☐

	YES	NO	UNKNOWN
GASTROINTESTINAL (Stomach)			
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Ulcers	☐	☐	☐
GENITOURINARY			
Chlamydia	☐	☐	☐
Gonorrhea	☐	☐	☐
Kidney Disease	☐	☐	☐
Syphilis	☐	☐	☐
INTEGUMENTARY (Skin)			
Eczema	☐	☐	☐
Psoriasis	☐	☐	☐
LYMPHATIC/HEMATOLOGIC			
AIDS	☐	☐	☐
Anemia	☐	☐	☐
Bleeding Disorders	☐	☐	☐
Hepatitis	☐	☐	☐
Herpes	☐	☐	☐
HIV Positive	☐	☐	☐
Liver Disease	☐	☐	☐
NEUROLOGIC			
Epilepsy	☐	☐	☐
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Seizures	☐	☐	☐
PSYCHIATRIC			
Depression	☐	☐	☐
High Anxiety	☐	☐	☐
REPRODUCTIVE			
Nursing Mother	☐	☐	☐
Pregnant	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Pneumonia	☐	☐	☐
Tuberculosis	☐	☐	☐
VASCULAR			
Diabetes	☐	☐	☐
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Stroke	☐	☐	☐

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: _____