

Pleasant View Eye Care
6292 Highway 41A Pleasant View, TN 37146

Patient Information

Last Name _____ First Name _____ MI _____ Date of Birth _____ SSN _____

Preferred Name _____ MR. Mrs. Miss. Dr. Jr. Sr. Male Female

Address _____ City _____ State _____ Zip _____

Phone (H) _____ (W) _____ (C) _____

Email Address _____ May we communicate with you by email? Yes ___ No ___

Employer _____

Marital Status: Single ___ Married ___ Other ___ Full Time Student: Yes ___ No ___

Emergency contact _____ Relationship _____ Phone _____

Insurance Information

Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract. To enable our office to file your insurance you must provide accurate information at each visit.

Primary Vision Insurance _____ Member Name /Subscriber ID _____

Policy holder (Guarantor) _____ Date of Birth _____ SSN _____

Address _____ City _____ State _____ Zip _____

Employer _____ Daytime Phone _____

Relationship to Patient _____

Secondary Vision Insurance _____ Member Name /Subscriber ID _____

Policy holder (Guarantor) _____ Date of Birth _____ SSN _____

Address _____ City _____ State _____ Zip _____

Employer _____ Daytime Phone _____

Relationship to Patient _____

Primary Medical Insurance _____ Member/Subscriber ID _____

Policy holder (Guarantor) _____ Date of Birth _____ SSN _____

Address _____ City _____ State _____ Zip _____

Employer _____ Daytime Phone _____

Relationship to Patient _____

Secondary Medical Insurance _____ Member/Subscriber ID _____

Policy holder (Guarantor) _____ Date of Birth _____ SSN _____

Address _____ City _____ State _____ Zip _____

Employer _____ Daytime Phone _____

Relationship to Patient _____

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Health History

Primary Care Physician _____ Date of last Visit _____

Pharmacy _____

Date of last eye exam _____ Location _____

Do you wear glasses? _____ If yes, what do you use your glasses for? _____

Do you wear contacts? Brand _____ Hours per day _____

Are you currently pregnant? _____ Do you use tobacco? _____ Are you coming in for a work related injury? _____

Please list any medications you are currently taking, including eye drops: _____

Please list any allergies to medications or other substances: _____

Please **circle** any of the following conditions that you are currently experiencing

- | | | | |
|----------------|-----------------|-------------------|------------|
| Bloodshot eyes | Dry Eye(s) | Floaters/Spots | Eye Injury |
| Red eye(s) | Watering eye(s) | Light Sensitivity | Cataracts |
| Burning eye(s) | Discharge | Headaches | Glaucoma |
| Itching eye(s) | Double Vision | Crossed Eyes | |

Please circle **Yes(Y)** or **No (N)** to indicate if you or a family member have or have had any of the following

	<u>Yourself</u>	<u>Family</u>		<u>Yourself</u>	<u>Family</u>
AIDS/HIV	Y/N	Y/N	Hepatitis (Type ____)	Y/N	Y/N
Arthritis	Y/N	Y/N	High Blood Pressure	Y/N	Y/N
Asthma	Y/N	Y/N	Kidney Disease	Y/N	Y/N
Blindness	Y/N	Y/N	Lupus	Y/N	Y/N
Cancer	Y/N	Y/N	Migraine Headaches	Y/N	Y/N
Diabetes	Y/N	Y/N	Retinal Disease	Y/N	Y/N
Epilepsy	Y/N	Y/N	Shingles	Y/N	Y/N
Eye Surgery	Y/N	Y/N	Stroke	Y/N	Y/N
Glaucoma	Y/N	Y/N	Thyroid Conditions	Y/N	Y/N
Hay Fever	Y/N	Y/N	Turned Eye	Y/N	Y/N
Heart Condition	Y/N	Y/N			

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HIPAA Release Form

I _____ give my permission for the following people to be able to access my records and payment information at Pleasant View Eye Care by phone or in person.

I _____ give my permission for Pleasant View Eye Care to leave a voicemail on the following phone lines.

Signature _____

Date _____

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Patient Consent and Release to Receive Emails

You have agreed to provide Pleasant View Eye Care with your email address. There are some limits on what and when we can email you.

Please note: We do not use email to provide test results or other clinical information.

- Please tell us which email address you wish to use. Don't forget to notify us if any changes to your email address.

- If you intend to receive our emails, please be sure to update your address book and check your junk/spam folder.
- Email should never be used in an emergency. If you gave an emergency, you should call 9-1-1 or go to the nearest emergency department.
- Email should never be used for urgent problems.
- If you have an urgent issue, please call the office @ 615-746-3931. If it's after hours our answering service will reach the physician.

Be Aware there are privacy risks in using email.

- Email is not secure. While we try to protect our emails we cannot guarantee the security and confidentiality of any email you receive from us. As the email is sent across the Internet it could be intercepted and read.
- Emails we send to you may be filed on your electronic health record depending on the email message and can become a permanent part of your health record. Emails can be used as evidence in court.
- If you use a work email, your employer may have a right to inspect and archive emails sent from their systems. We recommend you avoid using a work email.
- It is easy to forge, easy to forward (sometimes accidentally and to several people) and may exist forever.

1st Appt. Signature _____

Date _____

2nd Appt. Signature _____

Date _____

3rd Appt. Signature _____

Date _____

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615-746-3931

ACKNOWLEDGEMENT OF PRIVACY POLICY AND PRACTICES

I understand that in an attempt to protect the privacy of my identifiable health information, Pleasant View Eye Care has established a Privacy Policy and guidelines for Privacy Practices within our 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 HIPAA regulations, a copy of the Pleasant View Eye Care 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 provided at no charge.

- I have read, and understand and acknowledge the Privacy Policy and Practices of Pleasant View Eye Care.
- I have elected not to read the Privacy Policy and Practices of Pleasant View Eye Care.
- A copy of the Privacy Policy and Practices of Pleasant View Eye Care was given to me today.
- I have requested a copy of the Privacy Policy and Practices of Pleasant View Eye Care to be mailed to me.

Signature

Date

Print Name of Patient