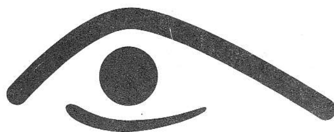
WELCOME



PLEASE COMPLETE BOTH SIDES OF THIS QUESTIONNAIRE BY FOLLOWING THE THREE EASY STEPS IN BLACK INK.

Step 1 PATIENT REGISTRATION

Patient ______________________________

Address ______________________________

____

City State Zip

Home Phone Number ______________________________

Work Phone Number ______________________________

Cell Phone Number ______________________________

E-Mail ______________________________

How did you find out about our practice? ______________________________

____

Sex ❐ M ❐ F Birthdate ______________________________

Married ❐ Single ❐ Divorced ❐ Widowed ❐

Social Security Number ______________________________

Occupation ______________________________

Employer ______________________________

Employer Address ______________________________

Employer Phone ______________________________

Spouse's Employer ______________________________

IN CASE OF EMERGENCY, CONTACT

Name ______________________________

Relationship ______________________________

Phone Number (H) ______________ (W) ______________

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 ______________________________

AUTHORIZATION

I certify I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eyecare to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits otherwise payable to me. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

______________________________ ______________

Signature of Patient (or parent if a minor) Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Terry L. Hendrickson, O.D. for services furnished me. 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

Step 3 MEDICAL HISTORY QUESTIONNAIRE

Primary Care Physician ______________________________

MEDICATIONS

- ______________ • ______________
- ______________ • ______________
- ______________ • ______________

Drug Allergies ______________________________

Describe all serious illnesses, injuries and surgeries: ______________

____

____

PRIVACY NOTICE AUTHORIZATION

I, ______________________________ hereby acknowledge that Family Eye Care, PLLC provided me with information of the Notice of Privacy Practices.

May we text you? ❐ Yes ❐ No

Signed: ______________________________

Date: ______________________________

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			Yes
Arthritis	_____	❐	Diabetes	_________	❐
Blindness	_____	❐	Glaucoma	_________	❐
Cancer	_______	❐	Heart Disease	_____	❐
Cataracts	______	❐	Hypertension	_____	❐
Crossed Eyes___		❐	Retinal Dt.	_________	❐

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
Computers	❐
Fishing	❐
Golfing	❐
Hunting	❐
Music	❐
Reading	❐

REVIEW OF SYSTEMS

CHECK THE SYMPTOMS AND/OR CONDITIONS YOU CURRENTLY HAVE OR HAD IN THE PAST.

EYES	Yes	No	Unknown
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	❐	❐	❐
Styles or Chalazion	❐	❐	❐
PROBLEMS WITH SYSTEMS			
Constitutional (fever, weight gain/loss)	❐	❐	❐
Ears, nose, mouth, throat	❐	❐	❐
Cardiovascular	❐	❐	❐
Respiratory	❐	❐	❐
Gastrointestinal	❐	❐	❐
Genitourinary	❐	❐	❐
Musculoskeletal	❐	❐	❐
Integumentary (skin and/or breast)	❐	❐	❐
Neurological	❐	❐	❐
Psychiatric	❐	❐	❐
Endocrine	❐	❐	❐
Hematologic/lymphatic	❐	❐	❐
Allergic / immunologic	❐	❐	❐

REASON FOR VISIT TODAY

____

____

BILLING POLICY FOR FAMILY EYE CARE

We are pleased to serve your eye health needs.

Our business office will gladly file insurance with most companies. However, we must have a current copy of your insurance card at the time of service in order to do so.

Patients with commercial insurance will be required to pay their co-pay payment(s) at the time of service.

We allow sixty (60) days from the date we file for the insurance company to pay its portion of the account. Your help in seeing that this claim is paid within this time is appreciated. ***Insurance claims which are denied, rejected, or not paid in full within sixty (60) days will be your personal obligation.*** Please present a current insurance card at the time of service. We cannot file insurance if not presented the day of service. However, we will be helpful with the information you need to file for yourself.

If you do not have insurance, payment for exams are expected to be paid in full at time of service.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THIS OFFICE FOR PAYMENTS IN FULL OF ALL MY ACCOUNTS. BY SIGNING THIS STATEMENT, I AGREE TO PAY FOR SERVICES NOT PAID IN WHOLE OR PART BY MY INSURANCE CARRIER. I REALIZE I AM RESPONSIBLE FOR ALL COLLECTION AND LEGAL FEES ASSOCIATED WITH ALL MY ACCOUNTS.

______________________________ ______________

Signed Date

DOCTOR'S USE

Reviewed:____/____/____	TLH / WS	Reviewed:____/____/____	TLH / WS	Reviewed:____/____/____	TLH / WS
Reviewed:____/____/____	TLH / WS	Reviewed:____/____/____	TLH / WS	Reviewed:____/____/____	TLH / WS
Reviewed:____/____/____	TLH / WS	Reviewed:____/____/____	TLH / WS	Reviewed:____/____/____	TLH / WS

Patient Dilation Consent

A complete eye exam includes the examination of the back side of the eye, the retina, to look for disease that may be affecting your eyes. In order to view the entire retina, pupil dilation OR retinal imaging is necessary.

<u>Option #1 Optomap Retinal Scan</u>

Our doctor highly recommends the Optomap, which utilizes a high- tech digital camera to give a panoramic view of the retina without dilation. **There is a $39 additional charge, which is not covered by any insurance plans unless it is medically necessary.**

<u>Option #2 Pupil Dilation</u>

Dilation drops will be put into both eyes. After about 15 minutes, the pupil will be enlarged so the doctor can use a bright light to view the retina. There is no addition charge for dilation.

Please initial below to indicate your choice:

_____ I want to do the Optomap retinal image.

_____ I want to be dilated today, and understand that my eyes will be sensitive to light and my near vision will be blurred for a few hours.

____

Printed name of patient   Date

____

Patient's Signature   Date

Patient Information & Medical History

First Name: ____________________________ Last Name: ___________________________________ Middle Initial: ______ Sex: **M / F**

Preferred Name: ________________________Birth Date: _________________________Social Security Number: ___________________________

Home Address: ____

Zip: ____________________ City: ____________________________ State: _______ What is your occupation? _______________________________________

Race: ☐ **African/African American** ☐ **Asian/Asian American** ☐ **Caucasian/European American** ☐ **Native American** ☐ **Other** ☐ **Decline**

Ethnicity: ☐ **Non-Hispanic** ☐ **Hispanic / Latino**

Height:__________ Weight:_________

How would you prefer we use to contact you? ☐ **Home** ☐ **Work** ☐ **Cell** ☐ **E-mail** E-mail address ____

Home Phone: (_______)__________________ Work Phone: (______)______________________ Cell Phone: (_______)________________________

Marital Status: ☐ **Single** ☐ **Married** How did you hear about us? _______________________ ***We must have a copy of all insurance cards on the day of service***

Primary Medical Insurance: ____ Secondary Medical Insurance: ___________________________________

Vision Insurance: _________________ Insured's Name_________________ Insured Social Security Number: __________________________________

Insured's Birth Date:____ Insured's Employer: ____

Family Doctor: ____ Family Dr. Clinic/Phone: ____

Family Members: ____ For ease of data transfer, are they patients at this office? **Y / N**

NOTICE OF PRIVACY PRACTICES: I/We have been offered a copy of Family Eye Care statement on privacy practices
AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Family Eye Care to release any medical or incidental information that may be necessary for medical benefit of in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.
CONSENT FOR TREATMENT: I/We hereby authorize Family Eye Care to administer diagnostic and medical procedures as may be necessary for proper health care.
OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider.
VISION PLAN COVERAGE: I/We understand that only one vision plan may be used for exam/materials per visit-per patient and that the vision plan to be used must be chosen before the exam occurs and can not be billed or changed at a later date.

SIGNATURE: ____ DATE: ____

CHIEF COMPLAINT

How can we help you today? In this space please check/explain any signs and/or symptoms you are experiencing. Medical insurance will only cover if there is a medical reason for the exam/test such as loss of vision, headaches, eye pain, eye itching or burning, redness, glaucoma, cataracts, floaters, dry eyes, etc.

☐ **Loss of vision** ☐ **Floaters** ☐ **Eye pain/soreness** ☐ **Glare** ☐ **Dry eyes**
☐ **Blurred vision** ☐ **Crossed eyes** ☐ **Watery eyes** ☐ **Light sensitivity** ☐ **Red eyes**
☐ **Double vision** ☐ **Flashes of light** ☐ **Sandy/gritty feeling** ☐ **Tired eyes** ☐ **Burning/itching**

Other (explain):

HISTORY OF PRESENT ILLNESS

Location *Which eye has the problem?* ☐ **Right** ☐ **Left** ☐ **Both**
Quality *How is it effecting you?* ☐ **Bothersome** ☐ **Aware** ☐ **Painful**
Severity *How severe is the problem?* ☐ **Mild** ☐ **Moderate** ☐ **Severe**
Duration *How long have you had the problem?* _______________________

Timing *Is it new, ongoing, returning?* ☐ **New** ☐ **Ongoing** ☐ **Returning**
Context *Associated w/:* ☐ **Infection** ☐ **Medical condition** ☐ **Injury** ☐ **Surgery**
Modifiers *Previous treatment?* ☐ **Drops** ☐ **Medication** ☐ **Other:** __________
Symptoms *Are there associated symptoms?* ☐ **Headache** ☐ **Other:** __________

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following (check all that apply):

☐ **No problems** ☐ **Diabetes** ☐ **High blood pressure** ☐ **Cancer**
Who: __________ ____________ ____________

Has anyone in your family been diagnosed with any of the following eye problems (check all that apply):

☐ **No problems** ☐ **Glaucoma** ☐ **Amblyopia** ☐ **Cataracts** ☐ **Macular degeneration** ☐ **Strabismus (eye turn)**
Who: __________ ____________ ____________ ___________________ ____________________

SOCIAL HISTORY

Tobacco Use ☐ Y ☐ N ☐ Former
If yes, what type do you use? ☐ Vape ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Dip/Snuff
How much per month do you smoke? ________________

Do you consume alcohol? ☐ Y ☐ N
If yes, how often do you drink? ☐ Socially ☐ Daily

CURRENT VISION Last Vision Exam_____________ Last Eye Doctor_______________

Glasses: Do you currently wear glasses? ☐ Y ☐ N *if yes, answer the questions below; if no, continue to contact lenses section:*
What type of lenses are in your glasses? ☐ Single vision ☐ Bifocal ☐ Trifocal ☐ No-line (Progressive)

Contact Lenses: Do you currently wear contact lenses? ☐ Y ☐ N *if yes, answer the questions below; if no, continue to past ocular history section:*
What type of contact lenses do you wear? ☐ Soft ☐ Rigid
What is the manufacturer/model of your contact lenses? ____________________________________
What are the powers of your contact lenses (if you know)? ____________________________________
How old are your current contact lenses? ______ Months / Years
Do you sleep in your contact lenses? _______ How many nights in a row? ____________________________
How often do you replace your contact lenses? ☐ Daily ☐ Weekly ☐ 2 weeks ☐ Monthly ☐ 3 months ☐ 6 months ☐ Annually
What solutions do you use to care for contact lenses? ☐ Renu ☐ Optifree ☐ Clear Care ☐ Boston Advance ☐ Boston Simplicity ☐ Optimum ☐ Other: ______

REVIEW OF SYSTEMS

Pregnant ☐ Y ☐ N

Ocular/Eye Problems
- Inflammatory disorder ☐ Y ☐ N
- Surgery ☐ Y ☐ N
- Glaucoma ☐ Y ☐ N
- Amblyopia (lazy eye) ☐ Y ☐ N
- Cataract ☐ Y ☐ N
- Retinal problems ☐ Y ☐ N
- Macular degeneration ☐ Y ☐ N
- Strabismus (eye turn) ☐ Y ☐ N
- Patching ☐ Y ☐ N
- Other ________

Constitutional Problems
- Cancer Type:___________ ☐ Y ☐ N
- Fatigue ☐ Y ☐ N
- Developmental disability ☐ Y ☐ N
- Other ________

Ears, Nose, Mouth, Throat Problems
- Laryngitis ☐ Y ☐ N
- Dry mouth ☐ Y ☐ N
- Hearing loss ☐ Y ☐ N
- Sinusitis ☐ Y ☐ N
- Other ________

Neurological Problems
- Cerebral palsy ☐ Y ☐ N
- Multiple sclerosis ☐ Y ☐ N
- Tumor ☐ Y ☐ N
- Epilepsy ☐ Y ☐ N
- Other ________

Psychiatric Problems
- Depression ☐ Y ☐ N
- Other ________

Cardiovascular Problems
- Vascular disease ☐ Y ☐ N
- Stroke ☐ Y ☐ N
- Congestive heart failure ☐ Y ☐ N
- Heart disease ☐ Y ☐ N
- High blood pressure ☐ Y ☐ N
- High Cholesterol ☐ Y ☐ N
- Other ________

Respiratory Problems
- Emphysema ☐ Y ☐ N
- Bronchitis ☐ Y ☐ N
- Pneumonia ☐ Y ☐ N
- COPD ☐ Y ☐ N
- Asthma ☐ Y ☐ N
- Other ________

Gastrointestinal Problems
- Colitis ☐ Y ☐ N
- Chron's disease ☐ Y ☐ N
- Ulcer ☐ Y ☐ N
- Other ________

Genitourinary Problems
- Prostate disease/cancer ☐ Y ☐ N
- STD Type:___________ ☐ Y ☐ N
- Kidney disease ☐ Y ☐ N
- Other ________

Musculoskelatal Problems
- Ankylosis spondylitis ☐ Y ☐ N
- Fibromyalgia ☐ Y ☐ N
- Muscular dystrophy ☐ Y ☐ N
- Osteoarthritis ☐ Y ☐ N
- Other ________

Skin Problems
- Rosacea ☐ Y ☐ N
- Psoriasis ☐ Y ☐ N
- Eczema ☐ Y ☐ N
- Other ________

Endocrine Problems
- Insulin dependent diabetes ☐ Y ☐ N
- Non-insulin diabetes ☐ Y ☐ N
- Hormonal dysfunction ☐ Y ☐ N
- Thyroid dysfunction ☐ Y ☐ N
- Other ________

Blood/Lymph Problems
- Large volume blood loss ☐ Y ☐ N
- Anemia ☐ Y ☐ N
- Rheumatoid arthritis ☐ Y ☐ N
- Other ________

Allergy/Immunologic Problems
- Environmental allergies ☐ Y ☐ N
- Drug allergies ☐ Y ☐ N
- Lupus ☐ Y ☐ N
- Other ________

Do you sometimes experience dry eyes? ☐ Y ☐ N
Are your eyes sensitive to sunlight? ☐ Y ☐ N
Do you work at a computer ? ☐ Y ☐ N
Problems with reflections and/or glare? ☐ Y ☐ N
Prefer not to wear your glasses at times? ☐ Y ☐ N
Interested in newer contact lens technology? ☐ Y ☐ N
Want information on thinner / lighter lenses? ☐ Y ☐ N
Want information on LASIK vision surgery? ☐ Y ☐ N
Want a non-surgical option to LASIK? ☐ Y ☐ N
Do you have any children? ☐ Y ☐ N
Do you spend time outdoors? ☐ Y ☐ N
Please list your sporting activities / hobbies:
____

List any medications you are currently taking: ☐ See List
____
____
____

List any medicine allergies:
____

List any other allergies:
____

Family Eye Care

Acknowledgement of Privacy Policy and Practices

Family Eye Care Privacy Policy and Practices provides information regarding how we may use and disclose protected health information about you. According to HIPPA regulations, you have the right to a copy of the Privacy Policy and Practices before signing this consent form. The terms of our Privacy Policy may change and you may obtain a revised copy through our office.

You have the right to request how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, the agreement will be honored.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, diagnosis, payment, and health care operations including: communications via email, telephone, text messaging, and mail for appointment scheduling and reminders.

You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent.

I understand that:

- Protected health information may be disclosed or used for the treatment, payment, or health care operations.
- Family Eye Care has a Privacy Policy and Practices and the patient has had the opportunity to review the policy.
- Family Eye Care reserves the right to change the Privacy Policy and Practices.
- The patient has the right to restrict uses of their information, but Family Eye Care does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will cease.
- Family Eye Care may condition treatment upon execution of this consent.

I HERBY AUTHORIZE THE FOLLOWING PERSON(S) TO HAVE ACCESS TO MY FINANCIAL AND MEDICAL RECORDS:

Name:___________________________________ Relation:_________________ Phone:________________________________

Name:___________________________________ Relation:_________________ Phone:________________________________

____ ______________________

Signature Date

I authorize that my email may be used to send contact and glasses prescriptions at the end of my visits. **________**

Initials

(If initials and email address not provided, prescription cannot be sent until written documentation provided to our office)

Verbal consent is not valid

403 N. Garden St
Columbia, TN 38401
Phone: 931-380-2020
Fax: 931-381-5411
Email: info@familyeyecarecolumbia.com

Contact Lens Prescription Signed Acknowledgement Form

We at Family Eye Care, want you to be safe, healthy, and comfortable with your contact lens wear. If you have any symptoms of an eye infection, please call our office immediately.

Symptoms of Eye Infection include:

- **Irritated, red eyes**
- **Worsening pain in or around the eyes—even after contact lens removal**
- **Light sensitivity**
- **Sudden blurry vision**
- **Unusually watery eyes or discharge**

Please sign below to acknowledge that we have your permission to email a copy of your contact lens prescription to you.

Patient signature:____

Email

Address:____

Date:_______________________