DYERSBURG FAMILY EYE CARE

Please answer all questions on front and back.

Name:	SS#:
Date:	Pharmacy:
Birth Date:	Height:
Reason for Visit:	Weight:
Last Eye Exam:	

Patient Ocular History

Currently Wear: ___ Glasses
___ Distance
___ Near
___ Both
Problems with Glasses: _____

_____

Currently Wear: ___ Contact Lenses
Brand _____

hours/day _____
Problems with Contacts: _____

_____

Check All That Apply

- ☐ Cataracts
- ☐ Poor Color Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Injury
- ☐ Blindness
- ☐ Floaters
- ☐ Glaucoma
- ☐ Headaches

- ☐ Use Eye Drops Brand_____

- ☐ Poor Night Vision
- ☐ Loss of Vision
- ☐ Red Eyes
- ☐ Poor Vision
- ☐ Lazy Eye
- ☐ Macular Degeneration
- ☐ Diabetic Retinopathy
- ☐ Eye Surgery
  Type: _____
  Date: _____
  Reason: _____

Alcohol Use

- ☐ None
- ☐ Social
- ☐ Above Average

Smoking History

- ☐ Never
- ☐ Former
- ☐ Daily
- ☐ Occasional
  _____ # Years
  _____ Packs/Day

Patient Medical History

Primary Physician's Name:_____ Last Visit:_____

Check All That Apply

- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Anemia
- ☐ Diabetes
- ☐ Gout
- ☐ Thyroid Disease
- ☐ Hepatitis
- ☐ Prostate Disorder
- ☐ Sexually Transmitted Disease
- ☐ Leukemia
- ☐ Sickle Cell Disease
- ☐ AIDS/HIV
- ☐ Herpes Simplex/Zoster
- ☐ Histoplasmosis
- ☐ Cancer (Type:_____)
- ☐ Other _____

- ☐ Lupus
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Myasthenia Gravis
- ☐ Osteoporosis
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Seizures
- ☐ Migraines
- ☐ ADD/ADHD
- ☐ Depression
- ☐ Asthma
- ☐ Bronchitis
- ☐ Lung Cancer
- ☐ COPD
- ☐ Emphysema
- ☐ Tuberculosis

Medications

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies to Medications

_____
_____
_____
_____
_____

Past Surgeries:_____

Family Medical History

	Relationship to you:		Relationship to you:
☐ Heart Disease	_____	☐ Cataracts	_____
☐ High Cholesterol	_____	☐ Glaucoma	_____
☐ High Blood Pressure	_____	☐ Macular Degeneration	_____
☐ Diabetes	_____	☐ Blindness	_____
☐ Cancer (Type:_____)	_____	☐ Lazy Eye	_____

☐ Other:_____

DYERSBURG FAMILY EYE CARE

Dr. Justin Schroeder
Dr. Jake Lewis
1502 Brayton Avenue
Dyersburg, TN 38024
731-285-5411

Privacy and Financial Policy

The personal information we obtain from you will be available to the doctors and workers of this practice for use in your care and obtaining payment for the services and products that you receive. In some instances, it may be necessary to release information to other health care providers for continued care and co-management. It also may be necessary at time to release your information to insurance companies, frame and lens manufacturers, pharmacies, etc.

It is your responsibility to provide our office with the correct vision and medical insurance information for yourself and your dependents. If your insurance information is incorrect or does not pay for services and/or materials provided, it is your responsibility to render payment.

If you want us to make information about your care, charges, or status of an order available to family member's inquiries, please indicate here (check all that apply):

☐ Spouse ☐ Parent ☐ Child ☐ Other _____

Our communication with you regarding your care will be according to the information you provided on our registration form. If you prefer an alternative means of communication, please inform us in writing.

You will have access to your information for review or transfer to others on your written request. We ask that you allow us adequate time to assemble and copy your information. In most cases, this should only take a few days. There will be a nominal charge to you for copying and handling these documents. If you tell us that the information we have is not accurate, we will make a good faith effort to correct such inaccuracies.

The purpose of our policies is to protect your privacy. Please let us know if there are other measures you would like us to take to protect your privacy in writing and we will comply, or if unable will inform you so.

I authorize the doctor to release any information including diagnosis, examination recorders, etc. rendered to me, my spouse, or child during my care at Dyersburg Family Eye Care to third party payers and/or health care practitioners when necessary. I authorize and request my insurance company to pay directly to the eye doctor. I understand that my insurance may pay less than the billed amount of service. I consent that I am responsible for payment of all services rendered on my behalf or on behalf of my dependents. By signing this form, I indicate that I have read this entire document.

X_____ Date:_____

You are entitled to a copy of this policy. Please request if you desire.

DYERSBURG FAMILY EYE CARE

Date:	SS#:
Name:	Birth Date: Age:
Address:	Sex: (circle) M F
City: State: Zip:	Marital Status: (circle) Married Single
Home Phone:	Occupation:
Work Phone:	Employer:
Cell Phone:	Employer Address:
Email:	City: State: Zip:

Medicare Authorization

I request that payment of authorized benefits be made either to me or on my behalf to Dyersburg Family Eye Care for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administrator 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 authorized release of medical information nexessary to pay the clain. 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 authorized releasing of the information to the insurance 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 deductibles, coinsurance and non-covered services. Coinsurance and the deductible based upon the charge determination of the Medicare carrier.

Signature of Beneficiary:_____ **Date:**_____

Legal Guardian Information
(For patients under 18)

Name:	Relationship to Patient:
Address:	Employer:
City: State: Zip:	Employer Address:
SS#:	City: State: Zip:
Birth Date:	

Guardian Signature:_____ **Date:**_____