



# WELCOME TO BLOUNT COUNTY EYE CENTER

ID #: \_\_\_\_\_

DATE: \_\_\_/\_\_\_/\_\_\_

## WHO ARE YOU?

Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_

Name You Go By \_\_\_\_\_ SSN \_\_\_\_\_

## ABOUT YOU

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_

Phone (type) \_\_\_\_\_ Alternate Phone (type) \_\_\_\_\_

I am Currently:

Employed  Student  Retired  Disabled  Not Employed  Other \_\_\_\_\_

Occupation \_\_\_\_\_ Employer/School \_\_\_\_\_

Race (Optional):

American Indian or Alaskan Native  Asian  Native Hawaiian  Hispanic

White (Hispanic)  White (Not Hispanic or Latino)  African American

Other Pacific Islander: \_\_\_\_\_  Other: \_\_\_\_\_

How did you hear about us?  Insurance  Mailer  Referred by Family or Friend

Community Event  Other: \_\_\_\_\_

## ABOUT INSURANCE

Primary Medical Insurance \_\_\_\_\_  Self  Spouse  Parent  Other

Secondary Medical Insurance \_\_\_\_\_  Self  Spouse  Parent  Other

Vision Benefit Plan \_\_\_\_\_  Self  Spouse  Parent  Other

## CONTACTING YOU

Please select the way(s) in which you would like Blount County Eye Center to attempt to contact you for appointment reminders, questions on your account, eye wear job status, etc.

Phone  Email  Mail  Text

## TODAY'S VISIT

Accompanied Today By: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Last Eye Exam: \_\_\_\_\_ Where?: \_\_\_\_\_

Were you referred to BCEC today by another physician?  No  Yes: \_\_\_\_\_

Briefly describe why you are seeking an eye exam today: \_\_\_\_\_

## MEDICATION

Please list all medications you are currently taking including all eye drops. Include any over-the-counter medications and / or supplements. Please indicate if you've provided a current list for today's exam.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medication Allergies: \_\_\_\_\_

Other Allergies: \_\_\_\_\_

## VITALS

Height: \_\_\_\_\_ feet and \_\_\_\_\_ inches. Weight: \_\_\_\_\_ pounds.

## SOCIAL HISTORY

Smoking History:  No History of Smoking

Current Smoker. Amount/Day: \_\_\_\_\_  Former Smoker. Amount/Day: \_\_\_\_\_

Drug Use:  No  Yes: \_\_\_\_\_

Alcohol Use:  No  Yes. Frequency: \_\_\_\_\_

## FAMILY MEDICAL HISTORY

Does a member of your family have, or have they had, any of the following conditions? Please indicate who next to the appropriate condition.

Cancer \_\_\_\_\_  Diabetes \_\_\_\_\_  Cataracts \_\_\_\_\_

Glaucoma \_\_\_\_\_  Macular Degeneration \_\_\_\_\_

High Blood Pressure \_\_\_\_\_  Other \_\_\_\_\_

## REVIEW OF SYSTEMS

Check any of the following conditions that apply to you:

### CONSTITUTION

- Cancer
- Headache
- Developmental Disabilities

### EAR / NOSE / THROAT

- Sinus Condition
- Hearing Loss
- Dry Mouth
- Laryngitis

### NEUROLOGICAL

- Migraines
- Epilepsy
- Tumor
- Stroke
- Multiple Sclerosis
- Cerebral Palsy
- Autism Spectrum Disorder

### PSYCHOLOGICAL

- ADD / ADHD
- Depression
- Anxiety
- Bipolar Disorder

### MUSCULOSKELETAL

- Fibromyalgia
- Arthritis
- Muscular Dystrophy
- Gout

### RESPIRATORY

- Bronchitis
- Sleep Apnea
- Asthma
- Emphysema
- Cigarette Smoker
- Chronic Obstruction

### GASTROINTESTINAL

- Colitis
- Crohn's Disease
- Celiac Disease
- Acid Reflux
- Ulcer

### GASTROURINARY

- Kidney Disease
- Prostate Disease / Cancer
- STD
- Benign Prostate
- Hypertrophy
- Pregnant
- Nursing
- Herpes
- Chlamydia

### CARDIOVASCULAR

- Heart Disease
- High Blood Pressure
- Vascular Disease
- Congestive Heart Failure

### INTEGUMENTARY

- Rosacea
- Shingles
- Psoriasis
- Eczema
- Cold Sores

### ENDOCRINOLOGY

- Type 1 Diabetes
- Type 2 Diabetes
- Thyroid Condition
- Hormone Disorder

### BLOOD DISORDER

- Anemia
- High Cholesterol
- Larger Volume Blood Loss
- Ulcer

### IMMUNOLOGICAL

- Lupus
- Rheumatoid Arthritis
- Sjogren's Syndrome
- Drug Allergies
- Environmental Allergies

Primary Care Physician: \_\_\_\_\_ Do You Need One?  Yes  No

Other Medical Conditions: \_\_\_\_\_

Surgical History: \_\_\_\_\_

## CONSENT FOR MESSAGES

I give permission to the physicians and their staff at BCEC to (initial chosen options):

### TEXT AND VOICE MESSAGES FOR GENERAL HEALTHCARE INFORMATION:

\_\_\_\_\_ Leave text and voice messages at the following phone numbers for appointment reminders, office hours, general office reminders, and point of care notifications regarding my healthcare when I am not available.

\_\_\_\_\_ Leave voice messages regarding my health information including results and diagnostic information, payments of balance, care plans, referrals, when I am not available at the following number.

Cell \_\_\_\_\_ Phone \_\_\_\_\_

### SHARING OF YOUR HEALTH INFORMATION AND RESULTS

\_\_\_\_\_ I give permission to the physicians and staff at BCEC to share my health information including results, diagnoses, and appointment information with the following person(s).

*The persons you list will also be permitted to pick up prescriptions on your behalf if you are unable.*

Name	Relation	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____



**If all of the information listed is accurate, please sign below.  
Thank you for choosing BCEC!**

Patient Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_



# WELCOME BACK

ID #: \_\_\_\_\_

DATE: \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_

Please take a moment to review the information from your most recent visit. Mark out any information that has changed, or feel free to write any updates you wish on this page.

## UPDATES:

*I was able to review and update all of my personal and health information today, and verify that it is all now accurate.*

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Relationship to Patient: \_\_\_\_\_

## ACCOUNT, PAYMENT, & REFUND POLICIES

Initials: \_\_\_\_\_

I understand that all fees for products and/or services not covered by insurance and co-pays are due at the time of service. I understand that any balances not covered by my insurance will be my responsibility. Outstanding balances will be sent in statement form via USPS. Delinquent accounts will be turned over to collections when necessary, and I will be responsible for both my account balance as well as any fees incurred on behalf of BCEC from the collections agency. Orders for eyewear products cannot be placed until payment is made. Professional fees for exams cannot be refunded once performed. Product refunds over \$25 must be processed and will be issued by check. In the event of returned eyewear there may be frame and/or lens restocking & return fees. By signing below I acknowledge understanding and acceptance of these policies.

## AUTHORIZATION FOR INSURANCE PAYMENTS

Initials: \_\_\_\_\_

We request your signature on file in the event the office files insurance for you. This clause applies to all insurance and vision benefit carriers. This signature will serve as authorization for the lifetime of the patient for which it is on file. I request that payment of authorized carrier of Medicare benefits be made either to me or on my behalf to Blount County Eye Center for any services furnished me by this/these doctors. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

## AUTHORIZATION FOR INSURANCE PAYMENTS

Initials: \_\_\_\_\_

I have had the opportunity to receive a copy of this practice's Notice of Privacy Practices. The notice provides the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise those rights, and the practice's legal duties with respect to my protected health information. I understand that the practice may change the terms of its Notice of Privacy Practices and that any changes apply retroactively to information created while the current notice is in effect. I understand I can obtain this practice's current Notice of Privacy Practices upon request.

## VISION VS. MEDICAL EYE HEALTH EXAMS

Initials: \_\_\_\_\_

Both vision plans and medical insurances cannot be billed on the same date of service without risk of denial and balances being transferred to patients. Our physicians will address the most pressing eye health issue and bill appropriately, but this may require multiple visits to completely care for your eye health care needs. You will be informed when this is the case.

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Relationship to Patient: \_\_\_\_\_

One of the most important parts of today's comprehensive eye exam is the examination of the inside part of your eye, the retina. A healthy retina is critical to your vision, and needs to be examined for such conditions as macular degeneration, glaucoma, retinal holes, retinal detachments and complications from diabetes, high blood pressure and high cholesterol.

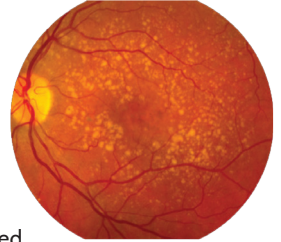
## THERE ARE TWO METHODS FOR THE BCEC EYE DOCTORS TO PROPERLY EVALUATE YOUR RETINA

### DILATION OF THE PUPIL

This traditional procedure allows your eye doctor a 3D evaluation of the retina using eye drops to enlarge and stabilize your pupils. They then use a high-powered microscope and magnifying lenses to view inside your eyes. The drops used will cause your vision to be blurred and your eyes to be sensitive to lights/sunlight for 2-4 hours in most cases. Patients with diabetes or retinal symptoms should be dilated on a yearly basis.

### HIGH-DEFINITION RETINAL IMAGING

This technology offers an ultra-wide view of the retina and allows your eye doctor to instantly evaluate your retinal health. In many cases, in otherwise healthy patients, dilation is not required if photos are evaluated. These digital images can be stored for future use in detection of subtle retinal changes. They can also be sent to other physicians in the event that you ever require co-managed care.



THE MOST THOROUGH RETINAL EVALUATION WOULD BE TO HAVE BOTH PROCEDURES PERFORMED AS THEY COMPLEMENT EACH OTHER IN DETECTING SIGHT THREATENING CONDITIONS.

**THE EYE DOCTORS AT BCEC HIGHLY RECOMMEND AT LEAST ONE OF THESE TESTS TO COMPLETE YOUR COMPREHENSIVE EYE EXAM.**

During my comprehensive eye exam today, I would like:

- Dilation** (Included in your exam)
- High-Definition Retinal Imaging** (Additional \$25 charge, not covered by most insurances)
- Neither Procedure.** By choosing this option you agree to the following: I have chosen to have neither test performed against the recommendation of the BCEC eye doctors. I will not hold the physicians or practice responsible for any disease or pathology that goes undetected due to the lack of diagnostic information that could have been obtained through retinal imaging or dilation.

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_