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
_____	_____	_____
_____	_____	_____
_____	_____	_____

BCEC
BLOUNT COUNTY EYE CENTER

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: _____

BCEC
BLOUNT COUNTY EYE CENTER
www.BlountEye.com 865.982.6761

Practice Policy Agreement

Your Name: _____

ID#: _____DOB: _____/_____/_____

Account, Payment & Refund Policies

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. Initials: _____

Authorization for Insurance Payments

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. Initials: _____

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Vision vs. Medical Eye Health Exams

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.

Initials: _____

Please Sign Here: _____ **Date:** ____/____/____

Relationship to patient if guardian: _____

BCEC
BLOUNT COUNTY EYE CENTER
www.BlountEye.com 865.982.6761

Blount County Eye Center
COVD Quality of Life Checklist

Patient Name: _____ Date: _____ Completed By: _____

Check the column which best represents the occurrence of each symptom	Never 0	Seldom 1	Occasionally 2	Frequently 3	Always 4
Blurred Close Vision					
Double Vision					
Headaches With Near Work					
Words Run Together Reading					
Burning, Itchy, Watery Eyes					
Falls Asleep Reading					
Sees Worse at the End of Day					
Skips / Repeats Lines Reading					
Dizzy / Nauseated by Near Work					
Head Tilt / One Eye Closed to Read					
Difficulty Copying from Chalkboard					
Avoids Near Work / Reading					
Omits Small Words When Reading					
Writes Uphill / Downhill					
Misaligns Digits / Columns of Numbers					
Poor Reading Comprehension					
Holds Reading Too Close					
Trouble Keeping Attention on Reading					
Difficulty Completing Work on Time					
Says “I Can’t” Before Trying					
Avoids Sports / Games					
Poor Hand / Eye Coordination					
Poor Handwriting					
Does Not Judge Distance Accurately					
Clumsy, Knocks Things Over					
Poor Time Use / Management					
Does Not Make Change Well					
Loses Things / Belongings					
Car or Motion Sickness					
Forgetfulness / Poor Memory					
Total For Each Column:	_____x0 = 0	_____x1 =	_____x2 =	_____x3 =	_____x4 =

<15 = Routine Eye Exam Recommended	16 - 24 = Comprehensive Exam With Developmental OD Recommended	>25 = Developmental Vision Problem Likely, Comprehensive Exam with Developmental OD Strongly Recommended