Tennessee River Eye Clinic
Patient Information

Name _____ Birth Date _____ SSN _____

Address _____City _____ST _____ Zip _____

Cell _____ Home_____ Email_____

Sex: M F Preferred Language: [ ] English Other:_____ Ethnicity: [ ] Decline [ ] Hispanic [ ] Non-Hispanic

Marital Status: [ ] Single [ ] Married [ ]other _____

Occupation _____Place of employment_____

Race: [ ] Decline [ ] Caucasian(white) [ ]Black (African American) Asian[ ] American Indian [ ] Other_____

Spouse's Name _____ Birth Date _____ SSN _____

Financially Responsible Party

[ ] Patient [ ] Spouse [ ] Parent/Guardian [ ] Male [ ] Female

Name_____BirthDate_____SSN_____

Street address_____City_____ST_____Zip_____

Cell #_____ home_____ work/other_____ Email_____

Insurance

Insurance #1 (Primary Insurance- This will be filed first)

Insurance company_____ Contract Number _____Group number_____

Subscribers Last Name_____ First Name_____ Middle Name_____

Social security number_____ Date of birth_____ Sex M F

Relationship to patient _____

Insurance #2 (Secondary Insurance-This will be filed after primary insurance pays)

Insurance company_____ Contract Number _____Group number_____

Subscribers Last Name_____ First Name_____ Middle Name_____

Social security number_____ Date of birth_____ Sex M F

Relationship to patient _____

Insurance #3 (Tertiary insurance- This will be filed after primary and secondary insurance pays)

Insurance company_____ Contract Number _____Group number_____

Subscribers Last Name_____ First Name_____ Middle Name_____

Social security number_____ Date of birth_____ Sex M F

Relationship to patient _____

Emergency Contact

Name _____Relationship _____Cell_____

Tennessee River Eye Clinic
Patient Information

Initial in the boxes.

[ ] **After 2** no call-no show appointments, it will be documented in the patient's chart and a fee of **$50** will be assessed to the patient's account and may ultimately result in dismissal from our practice.

[ ] Best possible vision measurement or RX. This is a medically non-covered service. The fee is **$40.00** and is collected at time of service. We only collect if service is performed.

[ ] I have reviewed the Notice of Privacy Practices as provided at registration and understand that I may request a copy of the policy at any time.

[ ] I hereby authorize Dr. Kassels, Dr. Lenz and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition. **We recommend a driver.**

[ ] I consent to treatment at Tennessee River Eye Clinic and my consent remains effective until revoked in writing by me. You have the right at any time to discontinue services.

[ ] I authorize the release of any medical information necessary to process a claim on any insurance policy on file. I hereby assign to and authorize payment directly to Tennessee River Eye Clinic/Mark Kassels M.D./Jan Lenz O.D. of all benefits payable under Medicare, Medicaid or other insurance policy as well as any MEDIGAP Insurance. I understand that I am ultimately responsible for all charges, whether or not paid by my insurance. I also understand that, should I default on my account, all costs of attorney's fees, interest and cost of collections would be my responsibility.

Patient/Responsible party

Signature_____Date_____

Tennessee River Eye Clinic
Patient Information

Release of Information To Family/Friends Authorization

ONLY COMPLETE NAME/DOB/SSN/SIGNATURE/DATE

_____

Patients Name (Print) Date of Birth SSN

I authorize Tennessee River Eye Clinic to release my information to the following individuals:

_____

Name Relationship Phone

_____

Name Relationship Phone

[ ] ***I do not want anyone to have access to my protected health information unless I provide explicit authorization***.

_____

Signature (patient or representative) Date

_____

Witness signature Date

Release of Medical Records to Physician Authorization

ONLY COMPLETE NAME/DOB/SSN/SIGNATURE/DATE

_____

Patients Name (Print) Date of Birth SSN

I request that:

_____

Doctor/Hospital/Facility Name

_____

Address

_____

City State Zip

Release my medical records to Tennessee River Eye Clinic for the purpose of continuity of medical care.

_____

Patients signature Date

_____

Witness signature Date

Tennessee River Eye Clinic
Patient Information
New Patient History
Blank answers will be recorded as no/negative in your electronic record.

Name_____ **Date of birth**_____

What is your current eye problem? _____

List all allergies _____

Past Eye history: **Other eye doctor(s)** _____

Problems: _____
Prior Eye Surgery: _____
Current eye medicines: _____

Do you now or have you ever had…..
[ ] contact lenses, [ ] glaucoma, [ ] macular degeneration, [ ] cataracts, [ ] flashes or floaters?
[ ] dry eyes, Explain_____

Past medical history: **Primary Medical Doctor**_____

[ ] Diabetes	[ ] Thyroid problems	[ ] High blood pressure	[ ] Stroke
[ ] COPD	[ ] Cancer	[ ] Arthritis	[ ] Other problems:

-

_____
_____
_____

Past surgery:

_____
_____
_____

Name of medication/dosage/how taken

_____
_____
_____
_____
_____

Family history:
[ ] Glaucoma_____
[ ] macular degeneration_____
[ ] Retinal tear/detachment_____
[ ] cataract_____
[ ] other eye disease or blindness_____

Do you smoke? [ ] _____packs/day
Are you currently vaccinated for flu: [ ] Yes [ ] No Pneumonia: [ ] Yes [ ] No
Have you fallen more than once in the past year? [ ] Yes [ ] No

Sign here_____ Date _____

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