PATIENT REGISTRATION

Patient_____ Date_____

Address_____
City State Zip

Home Phone_____ Work Phone_____

Cell Phone_____ Text ☐ Yes ☐ No Sex ☐ M ☐ F

Birthdate_____ Age_____ Social Security Number_____

Email _____ Height _____ Weight_____

Employer_____ Race ☐ Caucasian ☐ African American

Referred By _____ ☐ Hispanic ☐ Asian ☐ Other

IN CASE OF EMERGENCY

Name_____ Relationship_____

Home Phone_____ Work Phone_____

FINANCIAL RESPONSIBILITY

Who is responsible for this account?_____ Birthdate_____

Relation to patient_____ Social Security Number_____

The responsible party is responsible for payment in full of all services or charges rendered by Joslin Eye Center, P.C. reguardless of insurance coverage. Please remember that most insurance companies do not cover all charges in full. Since insurance is a contract between you and your employer or you and the insurance company, you are responsible for any balance for services rendered regardless of any insurance coverage you may have. In the event this account becomes delinquent, the undersigned agrees to pay any necessary collection fees/attorney fees of **no less than 40% added to the unpaid balance**, and court costs.

_____

Responsible Party Signature Date

ASSIGNMENT AND RELEASE

I assign all insurance benefits for services rendered, payable directly to Joslin Eye Center, P.C. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorized the use of this signature on all insurance submissions.

_____

Responsible Party Signature Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have read a copy of the NOTICE OF PRIVACY PRACTICES of Joslin Eye Center, P.C. I understand that signing this acknowledgement is not a requirement to receive treatment by Joslin Eye Center, P.C.

_____

Responsible Party Signature Date

_____ _____ _____ _____ _____

PLEASE TURN OVER TO COMPLETE SIDE 2

MEDICAL HISTORY QUESTIONNAIRE
PAST PERSONAL HISTORY

MEDICATIONS

- _____
- _____
- _____
- _____
- _____
- _____

DRUG ALLERGIES_____

Primary Care Physician_____

Previous Eye Doctor_____

Last Eye Exam_____

Describe all serious illnesses, injuries and surgeries you have had in the past:_____

_____

FAMILY HISTORY

Please note any family member with the following diseases/conditions

M-Mother **F**-Father **S**-Sibling **GP**-Grandparent

	YES	NO		YES	NO
Arthritis _____	☐	☐	Diabetes_____	☐	☐
Blindness _____	☐	☐	Glaucoma _____	☐	☐
Cancer _____	☐	☐	Heart Disease _____	☐	☐
Cataracts _____	☐	☐	Hypertension _____	☐	☐
Crossed Eyes _____	☐	☐	Retinal Disease _____	☐	☐

SOCIAL HISTORY

Check which substances you use and consumption

Alcohol ☐ YES ☐ NO Quantity:_____

Drugs ☐ YES ☐ NO Quantity:_____

Tobacco ☐ YES ☐ NO Quantity: _____

Height _____ Weight_____

REVIEW OF SYSTEMS

Check the symptoms and/or conditions you currently have

EYES	YES	NO	?
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	☐	☐	☐
Styes or Chalazion	☐	☐	☐
BONE/JOINT/MUSCLE			
Arthritis	☐	☐	☐
Joint/Muscle Pain	☐	☐	☐
Polio	☐	☐	☐
CANCER	☐	☐	☐
ENDOCRINE			
Thyroid Abnormalities	☐	☐	☐
EAR, NOSE, AND THROAT			
Allergies	☐	☐	☐
Chronic Cough	☐	☐	☐
Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐

	YES	NO	?
GASTROINTESTINAL (Stomach)	☐	☐	☐
INTEGUMENTARY (Skin)			
Eczema	☐	☐	☐
Psoriasis	☐	☐	☐
LYMPHATIC/HEMATOLOGIC			
AIDS	☐	☐	☐
Anemia	☐	☐	☐
Bleeding Disorders	☐	☐	☐
Hepatitis	☐	☐	☐
HIV Positive	☐	☐	☐
Liver Disease	☐	☐	☐
Kidney Disease	☐	☐	☐
NEUROLOGIC			
Epilepsy	☐	☐	☐
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Seizures	☐	☐	☐
PSYCHIATRIC			
Depression	☐	☐	☐
High Anxiety	☐	☐	☐
REPRODUCTIVE			
Pregnant/Nursing	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Pneumonia	☐	☐	☐
Tuberculosis	☐	☐	☐
VASCULAR			
Diabetes	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Stroke	☐	☐	☐
Heart Disease	☐	☐	☐

List any other health conditions not mentioned above_____

Doctors Signature_____ Date_____

Dr. Brian Joslin
Dr. Bryce Joslin
Optometrists

Drs. Joslin & Joslin EYE CENTER

125 Peacock Court
Seymour, TN 37865
(865) 577-2002
Fax (865) 577-2046

WELCOME TO THE 21ST CENTURY

Dear Patient,

A new, highly sophisticated computerized instrument now allows us to provide you with a more thorough medical analysis of your eye. The digital retinal imaging system takes images of the retina (the back of your eye), and other structures inside the eye. The procedure assists the doctor in the early detection of many disorders including glaucoma, diabetic retinopathy, macular degeneration, retinal detachments and other vision threatening conditions. **The images will be stored in our data base and compared with images from future exams. This allows the doctor to observe even the smallest amount of change from the previous procedure.**

The doctor strongly recommends that **all patients** have this procedure performed. It is especially important for people who:

1) are new patients
2) decline dilation
3) have never had the procedure
4) have headaches
5) see spots or flashes
6) have a family history of diabetes
7) have a family history of glaucoma
8) have a family history of high blood pressure
9) have high cholesterol
10) have reached the age of 40
11) have experienced sudden vision changes

There is an additional charge of $39 for this procedure. If a diagnosis is made during the examination, additional imaging may be performed and billed to your medical insurance. Please check the appropriate line below and sign.

_____ **I DO** want the procedure performed. Date _____

_____ **I DO NOT** want the procedure performed. Date _____

Signature _____

HIPAA Right of Access

May we notify you via **TEXT** appointment reminders and to let you know your purchased materials are available for pick up? YES NO Phone number_____

May we notify you via **EMAIL** appointment reminders and to let you know that your purchased materials are available for pick up? YES NO Email _____

Which types of communication do you prefer? TEXT Email Phone

Who may have access to your protected health information?

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____

Please print the name of the individual giving this authorization Date of birth

_____

Signature of the individual giving this authorization Date

Clinical Vision Evaluation Form

To provide you with the best vision possible, we need to know a little more about you. Please fill in the blanks below regarding your vision needs.

Name _____ Date _____

Are you having vision difficulties at _____ work _____ school _____ play

Occupation: _____ List your hobbies: _____

Do you spend any time?

Outdoors _____ yes - Any concerns with: _____ glare _____ sunlight _____ safety

Driving _____ yes - Any concerns with: _____ glare _____ sunlight _____ night vision

Playing sports _____ yes - Any concerns with: _____ safety _____ sunlight _____ durability

Computer/TV _____ yes - Any concerns with: _____ glare _____ sunlight _____ focus

Are your eyes sensitive to sunlight? _____ yes _____ no _____ Interested in Sunglasses

Do you wear glasses? _____ yes _____ no

Do you wear contacts? _____ yes _____ no

If you currently wear glasses, what would you change about them?

_____ style ____ more comfort ____ thinner lenses ____ safer _____sun protection

_____ less glare ____ more durable ____ invisible bifocal

For Doctors Use Only

1. Your primary correction _____

_____

2. Your secondary correction _____

_____

3. Your special vision _____

_____

4. Your recreation vision _____

_____

Glasses Contacts Comments _____