Retina Specialists of Tennessee, PLLC
Vitreoretinal Medicine, Surgery, & Ophthalmic Oncology
(423) 521-2820

PLEASE COMPLETE THE DEMOGRAPHIC AND MEDICAL HISTORY FORMS BEFORE ARRIVING FOR YOUR APPOINTMENT. YOU SHOULD PRESENT THESE TO THE RECEPTIONIST AT THE TIME OF CHECK IN. YOUR EYES WILL BE DILATED EACH VISIT SO PLEASE BRING A DRIVER IF NEEDED.

Dear Patient,

Welcome to Retina Specialists of Tennessee, PLLC. The focus of our practice is to treat diseases of the retina and vitreous as well as tumors of the eye. Our greatest goal is to provide you with quality care and a positive experience. For more information about our practice and physician, you may visit our website at http://www.retinatn.com.

During the visit, a thorough evaluation will be performed. This may include a medical history, a detailed examination, and diagnostic testing. The time required is typically lengthier than a general eye exam so please plan accordingly. Please bring a list of all current medications, any drug allergies, and the name and contact information of your other doctors.

We ask that you arrive at least ten minutes before your scheduled appointment to allow time for registration and collecting insurance information. Should you be running late or need to reschedule, please call as soon as possible so that we may adjust the schedule. We will try to accommodate patients who arrive late, but this is not always possible without adversely affecting other patients.

Parking is available in the parking deck and valet parking is at no additional charge. We are located on the 2nd floor of the Medical Mall at Erlanger Medical Center. A shuttle runs during the day to assist patients across the skywalk from the parking deck into the Medical Mall. Please take the "C" elevators up to the 2nd floor. We are in Suite C-230 at the end of the main corridor.

Thank you for choosing Retina Specialists of Tennessee, PLLC. We look forward to serving you.

APPOINTMENT TIME:_____

APPOINTMENT DATE:_____

Patient Profile

Doctor: _____ Appointment Doctor: _____

PATIENT INFORMATION

Name: _____ Patient ID #: _____ Sex: [ ]M [ ]F

Address: _____ Date of Birth: _____

_____ Social Security #: _____

City,State, Zip: _____ Marital Status: [ ]Married [ ]Single [ ]Divorced

Phone: _____ [ ]Home [ ]Work [ ]Other Patient e-mail address: _____

Phone: _____ [ ]Home [ ]Work [ ]Other Language: _____

Race: _____ Ethnicity: _____

PATIENT EMPLOYMENT

[ ]Employed [ ]Retired [ ]Unemployed [X]Other

Phone: _____

Employer: _____

CONTACTS

_____

_____

_____

RESPONSIBLE PARTY

[X]Same as Patient

Name: _____

Address: _____

_____

City,State: _____

RESPONSIBLE PARTY EMPLOYER

Employer: _____

Phone: _____

Phone: _____

Social Security #: _____

Date of Birth: _____

PRIMARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: _____

Insured Phone: _____

Company: _____

Relationship to Primary Insured/Guarantor: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

Date of Birth: _____

SECONDARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: _____

Insured Phone: _____

Company: _____

Relationship to Primary Insured/Guarantor: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

Date of Birth: _____

Appt Date & Time _____

CONSENT TO TREAT: I authorize the provider responsible for care of the above named patient to provide diagnosis and treatment of services.

FINANCIAL RESPONSIBILITY: I agree to be personally responsible and fully responsible for payment for services rendered in accordance with any insurance benefits where applicable. I understand that I am financially responsible for charges not covered by my plan or for claims denied because of my failure to comply with conditions set by my insurance carrier. These conditions may include but are not limited to: failure to make co-payment or obtain a written referral for services provided by someone other than my primary care physician. A finance charge of 1½% per month (annual percentage rate 18%) of the unpaid balance will be added monthly. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs.

ASSIGNMENT OF BENEFITS: I request insurance benefits for services provided by paid directly to the medical clinic. I verify the accuracy of the above listed demographic and insurance information and I authorize the release of any medical information necessary to process payment for services provided.

Signature _____ Date _____

PRIVACY OPTIONS

Please respond to the questions below to assist us when we cannot reach you.

1. May we leave a message on your answering machine regarding appointments?
   YES (please circle one) NO

2. May we speak with the person answering your home phone regarding appointments?
   YES (please circle one) NO

3. May we speak with other people regarding your billing, insurance, or financial arrangements?
   YES (please circle one) NO

   If yes, to whom may we speak?_____

4. May we speak with other people regarding test results or other medical information?
   YES (please circle one) NO

   If yes, to whom may we speak?_____

   _____

My signature below indicates that I have received a copy of the Privacy Policies of Retina Specialists of Tennessee, PLLC

Signature: _____ **Date**: _____

Retina Specialists of Tennessee, PLLC
Vitreoretinal Medicine, Surgery, & Ophthalmic Oncology
979 East 3rd St. Suite #230
Chattanooga, TN 37350
423-521-2820

Medical History

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Gender: _____

Eye Doctor: _____ Phone: _____

Primary Care Doctor: _____ Phone: _____

PRESENT ILLNESS

Please describe your eye problem: _____
_____
_____

EYE HISTORY

Have you ever had any eye disease, eye surgery, or eye injury? ☐ No/ ☐ Yes
If yes, please describe including dates:

Doctor: _____ Date:_____ Describe:_____

_____

Doctor: _____ Date:_____ Describe:_____

_____

Has a previous eye disorder resulted in vision loss? ☐ No/ ☐ Yes
If yes, please describe: _____
Have you been diagnosed with a lazy eye or amblyopia? ☐ No/ ☐ Yes

MEDICAL HISTORY

Have you been diagnosed with any of the following?

High blood pressure……....	☐ No/ ☐ Yes
Coronary Artery Disease or a Heart Attack…….....	☐ No/ ☐ Yes
High Cholesterol……	☐ No/ ☐ Yes
Arrhythmia…….	☐ No/ ☐ Yes
Auto-Immune Disease…..……..	☐ No/ ☐ Yes
Heart Failure……..…….….	☐ No/ ☐ Yes
Renal Failure…...…….....……...	☐ No/ ☐ Yes
Other:	

Please describe any other medical problems:
_____
_____
_____
_____
_____

Have you ever been hospitalized for any reasons? ☐ No/ ☐ Yes
If yes, please describe: _____
Have you ever had major surgery? ☐ No/ ☐ Yes
If yes, please describe: _____
_____
Have you ever had complications from anesthesia? ☐ No/ ☐ Yes

Do you have Diabetes Mellitus? □ No/ □ Yes ……How long have you been diabetic? _____ years
If yes, which Type? Type 1/Juvenile Onset □ Type 2/Adult Onset □ Unknown/Other □
Are you on insulin?.....□ No/ □ Yes
How often do you check your blood sugar? _____
What was your last blood sugar measurement and your last HgB A1c?_____ /_____
Who is your diabetes doctor? _____
Have you developed complications from diabetes (kidney or eye disease, neuropathy, etc)?... No/ Yes

SOCIAL HISTORY

Education (please check all that apply):……	High School □ College □ Graduate Degree □ Other:_____
Work History:……...…	Working? □ No/ □ Yes Retired? □ No/ □ Yes Occupation:_____
Family:……...	Married □ Single □ Divorced □ Widowed □ Other:_____
Lifestyle:……	Do you use illegal drugs or abuse medications?.....□ No/ □ Yes Do you drink alcohol?.....□ No/ □ Yes If yes, how many drinks per week? _____ Do you smoke or chew tobacco?.....□ No/ □ Yes If no, are you a former smoker?.....☐ No/☐ Yes Are you disabled?..... ☐ No/☐ Yes

FAMILY HISTORY

Is there any eye disease in your family? □ No/ □ Yes
If yes, please describe: _____
Has any family member had a retinal problem (retinal detachment, macular degeneration, others? □ No/ □ Yes
If yes, please describe: _____
Does any family member have significant medical diseases (heart, lung, kidneys, cancer, GI)? □ No/ □ Yes
If yes, please describe: _____

ALLERGIES

Do you have a drug or latex allergy? □ No/ □ Yes
Please list all drugs and substances you are allergic to and your reaction:
_____
_____

MEDICATIONS (Please list all Medications and Dosage)

☐ No Prescription Medications ☐ See Attached List

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

Do you take any over the counter medications? □ No/ □ Yes
If yes, please describe: _____
Do you take any vitamins, herbal supplements, or holistic remedies? □ No/ □ Yes
If yes, please describe: _____
Are you taking any type of blood thinner (aspirin, warfarin, lovenox, plavix, pradaxa)? □ No/ □ Yes

REVIEW OF SYSTEMS-Please answer all questions.

Cardiovascular **□ NONE**
Chest Pain? □ No/ □ Yes
Heart Failure? □ No/ □ Yes
Irregular Heart Beat? □ No/ □ Yes
Edema/Swelling in Feet? □ No/ □ Yes
Heart Valve Disease □ No/ □ Yes
Other?

Constitutional **□ NONE**
Fevers, Weight loss, or Fatigue? □ No/ □ Yes

Respiratory **□ NONE**
Wheezing? □ No/ □ Yes
Emphysema? □ No/ □ Yes
Tuberculosis? □ No/ □ Yes
Asthma? □ No/ □ Yes
Other?

GI **□ NONE**
Heartburn or Acid Reflux? □ No/ □ Yes
Nausea and/or Vomiting? □ No/ □ Yes
Constipation? □ No/ □ Yes
Diarrhea? □ No/ □ Yes
Abdominal Pain? □ No/ □ Yes
Liver Problems? □ No/ □ Yes
Other?

Psychiatric **□ NONE**
Depression? □ No/ □ Yes
Anxiety? □ No/ □ Yes
Schizophrenia? □ No/ □ Yes
Memory loss or Alzheimers? □ No/ □ Yes
Other?

Head and Neck **□ NONE**
Ringing in Ears? □ No/ □ Yes
Sinus Disease? □ No/ □ Yes
Nosebleeds? □ No/ □ Yes
Oral Ulcers? □ No/ □ Yes
Other?

Hematology **□ NONE**
Easy bruising or bleeding? □ No/ □ Yes
Prior Blood Transfusions? □ No/ □ Yes
HIV positive or AIDS? □ No/ □ Yes
Hepatitis? □ No/ □ Yes
Venereal Disease (STD)? □ No/ □ Yes
Other?

Endocrine **□ NONE**
Diabetes Mellitus? □ No/ □ Yes
Thyroid Disease? □ No/ □ Yes
Heat or Cold Intolerance? □ No/ □ Yes
Excessive thirst or hunger? □ No/ □ Yes
Frequent Urination? □ No/ □ Yes
Other Glandular Disease?

Neurologic **□ NONE**
Stroke or TIA? □ No/ □ Yes
Seizure? □ No/ □ Yes
Neuropathy? □ No/ □ Yes
Other?

Genitourinary **□ NONE**
Kidney Disease? □ No/ □ Yes
Blood in urine? □ No/ □ Yes
Kidney or Bladders Stones? □ No/ □ Yes
Bladder Disease? □ No/ □ Yes
Other?

Orthopedic **□ NONE**
Joint Pain or Rheumatoid Disease? □ No/ □ Yes
Back stiffness or Pain? □ No/ □ Yes
Other?

Reproductive **□ NONE**
Are you Pregnant? □ No/ □ Yes

Skin? **□ NONE**
Rash or Nail Changes? □ No/ □ Yes
Other?