Knoxville Pediatric Ophthalmology, PLLC

PATIENT INFORMATION Date _____

Name _____ Spouse's Name _____

Birth Date: _____ Birth Date: _____

Soc. Sec.#: _____ Soc. Sec.#: _____

Address: _____ Address: _____

_____ _____

City State Zip City State Zip

Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

Place of Employment: _____ Place of Employment: _____

Occupation: _____ Occupation: _____

Employer's Address: _____ Employer's Address: _____

EMERGENCY INFORMATION

Name of nearest relative not living with patient

Name: _____ Phone#: _____ Relationship to Patient: _____

INSURANCE COVERAGE

PRIMARY COVERAGE

Ins. Company Name: _____

Address: _____

_____

(City, State, Zip)

ID#: _____

Group #: _____

Insured's Name: _____

Insured's Address: _____

_____

(City, State, Zip)

SECONDARY COVERAGE

Ins. Company Name: _____

Address: _____

_____

(City, State, Zip)

ID#: _____

Group #: _____

Insured's Name: _____

Insured's Address: _____

_____

(City, State, Zip)

FINANCIAL INFORMATION

How do you plan to pay for today's charges: Check _____ Visa _____ M/Card _____ Cash _____

Payment is expected at the time of service unless arrangements have been made in advance with our Financial Manager.

Are other members of your immediate family seen here? Yes ____ No ____

If so, please list their names: _____

Referred to our office by: _____

Address: _____

Family physician: _____

Address: _____

Do you wish a letter sent to your doctor containing our findings and recommendations? Yes _____ No _____

Knoxville Pediatric Ophthalmology, PLLC

Patient Registration

Date:

Patient Name: First, Middle, Last	Sex M F	Birth date: ____/____/____ Age	Patient's Social Security # _____-_____-_____

Address City State Zip

Mother's Birth date: _____/_____/_____ Home Phone# ( ) _____ Work phone# ( ) _____

_____ Social Security # _____-_____-_____ Cell phone# ( ) _____

Mother's Name:

Mother's Address: City State Zip

Employer: Occupation:

Father's Birth date: _____/_____/_____ Home Phone# ( ) _____ Work phone# ( ) _____

_____ Social Security # _____-_____-_____ Cell phone# ( ) _____

Father's Name:

Father's Address: City State Zip

Employer: Occupation:

Circle your relationship to the patient: Birth parent, Foster parent, Step parent, Grandparent, Legal Guardian, Adoptive parent, Other

Emergency Contact Name *not living with patient:* Relationship to patient:
Phone: ( ) _____

Primary Insurance	Is this insurance through an Employer? Yes No	
Subscriber Name:	Birth date: / /	Policy # Group #
Secondary Insurance	Is this insurance through an Employer? Yes No	
Subscriber Name:	Birth date: / /	Policy # Group #

Referred by:

_____

Address:

Family Physician/Pediatrician:

_____

Address:

_____

Would you like a letter sent to your doctor regarding your examination and recommendations? **Yes No**

Have any other members of your immediate family been seen here? Yes No

Person's Name: _____

Insurance Authorization for assignment of Benefits/Information Release:

I, the undersigned, authorize payment of medical benefits to Knoxville Pediatric Ophthalmology, PLLC for any services furnished by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning healthcare, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of

_____(Patients Name)

Parent/Guardian Signature: _____Date:_____

MEDICAL INFORMATION

EYE HISTORY

_____
PATIENT NAME

What problem are you having with your eyes? _____

Have you ever had an eye illness? ☐ Injury? ☐ Operation? ☐ . . . . . yes ☐ no ☐

If yes, please explain _____

Do you wear glasses? . . . . . yes ☐ no ☐ Bifocals? . . . . . yes ☐ no ☐

Prescribed by ☐ Optometrist ☐ Ophthalmologist

Do you wear contact lens? ☐ Soft ☐ Hard ☐ Extended wear ☐ Disposables. . . . . yes ☐ no ☐

Have you ever been told you have any of the following? . . . . . yes ☐ no ☐

☐ "Lazy Eye" ☐ "Crossed Eye" ☐ Color Blindness ☐ Learning Disability

Do you take eye medications? . . . . . yes ☐ no ☐

Do any of the following eye diseases run in your family?. . . . . yes ☐ no ☐

☐ Blindness ☐ Cataracts ☐ Color Blindness ☐ Crossed Eye ☐ Glaucoma ☐ Lazy Eye

When was your last eye examination by an eye Doctor? _____

MEDICAL HISTORY

Are you allergic to any of the following? . . . . . .yes ☐ no ☐

☐ Penicillin ☐ Sulfa ☐ Anesthetics ☐ Other _____

Are you taking any medications at this time ?. . . . . yes ☐ no ☐

Which medications? _____

Have you been told you have now or have had any of the following conditions?

Arthritis	☐	Diabetes	☐	Hydrocephalus	☐
Asthma	☐	Down's Syndrome	☐	Multiple Sclerosis	☐
Autism	☐	Epilepsy	☐	Rheumatic Fever	☐
Cancer	☐	Hearing Disorder	☐	Stroke	☐
Cerebral Palsy	☐	Heart Disease	☐	Thyroid Disease	☐
Developmental Delay	☐	High Blood Pressure	☐	Other _____	☐

_____