CHARLES D. ATNIP, M.D.
OPHTHALMOLOGY
MEDICINE AND SURGERY OF THE EYE

1050 N. James Campbell Blvd., Suite 100
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Telephone
(931) 381-2062

We appreciate the opportunity to see you for examination regarding your complete eye care.

First visits will take approximately one hour. Dilation of your eyes will probably be required as part of your examination. Dilation can take one to two hours to wear off, therefore we recommend that you arrange to have someone drive you home.

We will need your current insurance card(s). Please bring any current eye glasses, contacts lens or eye drops/medication list. Please be prepared to pay the refraction fee * as well as any co-pay required by your insurance carrier.

We ask that you complete the enclosed forms and if time allows, return them to us by mail in the envelope provided. Otherwise, please bring the completed forms and required information with you at the time of your appointment.

If you have any questions prior to your appointment, please call our office at (931) 375-1050 or toll free, 1-800-656-2503

Thank you.

Dr . Charles Atnip & Staff

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*REFRACTION Frequently Asked Questions:

-What is a refraction?

-Will my insurance pay for a refraction?

-Why do I need a refraction?

A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses.

Most medical insurance plans do not cover routine refractions as they consider it a vision charge rather than a medical charge. Our office fee for refraction is $20.00 and this fee is collected at the time of service. Should your insurance pay for the refraction, you will be refunded accordingly.

PATIENT INFORMATION

Name_____ Date_____

Date of Birth_____ Age____ M/F____ Social Security_____

Address_____

Street City State Zip

Phone: Home(____)_____ Work(____)_____ Cell(____)_____

Can you receive texts on your cell phone? ☐YES ☐NO Email address:_____

What are good ways to get in touch with you? (Check all that apply):

☐Cell Phone ☐Text Message

☐Home Phone ☐Other: _____

☐Email

Insurance Information

Primary Insurance: _____

Primary Insurance Subscriber (if not self): _____

Subscriber DOB: _____

Subscriber SS#: _____

Secondary Insurance: _____

Primary Insurance Subscriber (if not self): _____

Subscriber DOB: _____

Subscriber SS#: _____

Other Insurance: _____

Other Insurance Subscriber (if not self): _____

Subscriber DOB: _____

Subscriber SS#: _____

Employer_____ Phone(____)_____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced

Name of Spouse_____ Spouse's Date of Birth_____

Spouse's Social Security_____

Spouse's Employer_____ Phone(____)_____

Complete if patient is under 18 and/or a student 26 or under

Name of Father_____ Father's Date of Birth_____

Father's Soc Security_____

Father's Employer_____ Phone(____)_____

Name of Mother_____ Mother's Date of Birth_____

Mother's Social Security_____

Mother's Employer_____ Phone(____)_____

Referred by_____

Emergency contact (nearest relative or friend):

Name_____ Relationship_____ Phone: (____)_____

Signature_____ **Date**_____

(Patient or parent, if minor)

MEDICATIONS

Name:_____ Date:_____

Please list all medications, over-the-counter drugs, vitamins, and supplements you are currently taking:

ALLERGIES

Please list all drug and food allergies, including over the counter medications.

Allergic to:	**Describe reaction** (e.g. hives, shortness of breath, swelling, etc.)	**Describe severity** (mild, moderate, severe, fatal)

GENERAL MEDICAL HISTORY

Name:_____ Date:_____

Referred By: _____ Primary Care Physician: _____

Do you have currently, or have you had in the past, any of the following conditions?

			(About how old were you when you were diagnosed?)
Type-1 (Juvenile Onset) Diabetes	☐ Yes	☐ No	_____
Type-2 (Adult Onset) Diabetes	☐ Yes	☐ No	_____
Borderline Diabetes	☐ Yes	☐ No	_____

			(Write pertinent details here)
Eye disease/conditions (other than needing glasses)	☐ Yes	☐ No	_____
Eye Surgeries	☐ Yes	☐ No	_____
Premature birth (include birth weight)	☐ Yes	☐ No	_____
Arthritis	☐ Yes	☐ No	_____
Asthma	☐ Yes	☐ No	_____
Heart disease	☐ Yes	☐ No	_____
COPD	☐ Yes	☐ No	_____
High blood pressure	☐ Yes	☐ No	_____
Prostate problems	☐ Yes	☐ No	_____
Cancer	☐ Yes	☐ No	_____
Kidney disease	☐ Yes	☐ No	_____
Liver disease	☐ Yes	☐ No	_____
Thyroid problems	☐ Yes	☐ No	_____
Stroke	☐ Yes	☐ No	_____
Seizures	☐ Yes	☐ No	_____
Parkinson's disease	☐ Yes	☐ No	_____
Psychiatric problems	☐ Yes	☐ No	_____
Autism or Asperger's	☐ Yes	☐ No	_____
Mentally challenged or disabled	☐ Yes	☐ No	_____

Please list and describe any other medical issues you have that are not listed above _____

_____

Please list all past surgeries and approximate dates _____

_____

EYE HISTORY

When was your last eye exam?_____ By Whom? _____

Do you wear glasses? ☐ Yes ☐ No Contact lenses? ☐ Yes ☐ No How old are your glasses/contact lenses? _____

Do you have currently, or have you had in the past, any of the following eye conditions?

			(Write pertinent details here)
Cataracts	☐ Yes	☐ No	_____
Glaucoma	☐ Yes	☐ No	_____
Dry eyes	☐ Yes	☐ No	_____
Macular degeneration	☐ Yes	☐ No	_____
Crossed eyes or other misalignment	☐ Yes	☐ No	_____
Diabetic eye disease	☐ Yes	☐ No	_____
Floaters	☐ Yes	☐ No	_____
Other eye diseases/problems	☐ Yes	☐ No	Please list/describe any other eye diseases/problems below:

_____

_____

SOCIAL HISTORY INFORMATION

Name:_____ Date:_____

Race: ☐ African American or Black ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Decline to Specify ☐ Other_____

Ethnic Group: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Specify

Preferred Language:_____

Smoking Status: ☐Current every day smoker ☐Current some day smoker ☐ Former smoker
☐ Never smoker ☐ Heavy tobacco smoker ☐ Light tobacco smoker

If you smoke:

How many packs do you usually smoke per day? _____
About how long have you been a smoker? _____

Alcohol Use: ☐None ☐ Less than one drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

Driving status: ☐Does not drive ☐Drives in the daytime ☐Drives at night

FAMILY MEDICAL HISTORY

Is there a family history of any of the following:

		(Who in your family had this?)
Type-1 Diabetes	☐Yes ☐No	_____
Type-2 Diabetes	☐Yes ☐No	_____
Borderline Diabetes	☐Yes ☐No	_____
Glaucoma	☐Yes ☐No	_____
Macular degeneration	☐Yes ☐No	_____
Blindness	☐Yes ☐No	_____

Please list any other significant medical issues in your family that are not listed above. Be sure to note which member(s) of your family are affected. _____

_____

_____

_____

REVIEW OF SYSTEMS

Are you currently experiencing any of the following? Circle all that apply.

allergy to adhesive	eye pain	loss of vision	arthritis
allergy to lidocaine	tearing	high blood pressure	rash
allergy to penicillin	redness	rapid heart beat	headache
artificial heart valve	itching eyes	poor control of blood sugar	seizurestroke
blood thinners	burning eyes	thyroid abnormalities	paralysis
defibrillator	light sensitivity	fever	anxiety
Flomax (current or former user)	mucous in or around eye	chills	depression
MRSA	tired eyes	cough	autism or Asperger's Syndrome
narrow angles	feeling of object in eye	dry mouth	mentally challenged
premedication prior to procedures	contact lens discomfort	congestion	bleeding
pregnancy or planning a pregnancy	feeling of sand/grit in eye	wheezing	anemia
pseudoexfoliation syndrome	jaw pain	shortness of breath	allergies
poor vision	scalp tenderness	joint paint	hay fever
blurry vision	amaurosis fugax	stiffness	hives