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 (if Subscriber is not self)**

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__________________________ Spouse's 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)

Name:________________________ Date:________________________

Referred By: ________________________ Primary Care Physician: ________________________

Have you ever received a pneumonia vaccine? ☐ YES ☐ NO

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 ________

☐ Yes ☐ No ________

☐ Yes ☐ No ________

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........

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 anv other eve diseases/oroblems below:

________________________________________________

________________________________________________

## 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) |
|---|---|---|
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## 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
allergy to lidocaine
allergy to penicillin
artificial heart valve
blood thinners
defibrillator
Flomax (current or former user)
MRSA
narrow angles
premedication prior to procedures
pregnancy or planning a pregnancy
pseudoexfoliation syndrome
poor vision
blurry vision

eye pain
tearing
redness
itching eyes
burning eyes
light sensitivity
mucous in or around eye
tired eyes
feeling of object in eye
contact lens discomfort
feeling of sand/grit in eye
jaw pain
scalp tenderness
amaurosis fugax

loss of vision
high blood pressure
rapid heart beat
poor control of blood sugar
thyroid abnormalities
fever
chills
cough
dry mouth
congestion
wheezing
shortness of breath
joint paint
stiffness

arthritis
rash
headache
seizure/stroke
paralysis
anxiety
depression
autism or Asperger's Syndrome
mentally challenged
bleeding
anemia
allergies
hay fever
hives

THERE IS AN IMPORTANT TEST WE DO.

IT'S CALLED ... REFRACTION.

THAT'S WHERE THE TECH ASKS YOU QUESTIONS LIKE, "WHICH IS BETTER, ONE OR TWO?"

WHY DO WE DO THIS TEST? THERE ARE 4 REASONS.

1) IT REALLY HELPS US TO KNOW HOW HEALTHY YOUR EYES ARE.
2) IT'S THE ONLY WAY TO KNOW IF YOU NEED GLASSES OR IF YOUR GLASSES NEED TO BE CHANGED.
3) YOU CAN'T GET A NEW GLASSES PRESCRIPTION UNLESS WE DO THIS TEST!! SORRY, JUST CAN'T DO IT.
4) IF YOU WANT TO KNOW IF YOUR EYES QUALIFY FOR CATARACT SURGERY, YOU WILL PROBABLY HAVE TO GET THIS TEST DONE.

What are some reasons where it's ok to skip the test?

TURN PAGE OVER

1) Your vision is good, has not changed, and you do not want a glasses or contact lens prescription.
2) You are only here for a problem that does not involve your vision. Things like irritated, burning eyes or infections or injuries.
3) You were sent by another doctor for a specific problem not related to your vision.

THERE IS A $20 CHARGE FOR THIS TEST THAT INSURANCE DOESNT COVER!

WOULD YOU LIKE TO HAVE THE TEST DONE ___YES ___NO

SIGNATURE ______________________________________

1050 N. James Campbell Blvd. Ste. 100
Columbia, TN 38401

# FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below I give permission for Columbia Eye Associates to access my pharmacy benefits data electronically through SureScripts. This consent will enable Columbia Eye Associates to:

- Determine the pharmacy benefits and copays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider

In summary, we ask you permission to obtain formulary information, and information about other prescriptions prescribed by other providers using SureScripts.

______________________________ ______________
Patient Name (PRINTED) Date of Birth

______________________________ ______________
Patient/Guardian Signature Date

## FINANCIAL ASSIGNMENT AND AGREEMENT

1. Medical insurance is considered a method of reimbursing the physician and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. I understand that it is my responsibility to pay any deductible amount, co-insurance or any other amount not paid by my insurance.

2. I request payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

3. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

4. I agree to pay any and all unpaid balances, including but not limited to the principal balance of my bill, and if I am turned over to a collection agency or attorney for collections, I agree to pay those collection agency fees, attorney fees, and court costs.

**Name (Print)**____________________________________

**Signature**________________________________________ **Date**_______________

(Patient or parent, if minor)

## HIPAA POLICY

**The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established patient information privacy policies. The privacy policies were last updated September 23, 2013.**

I have been offered a copy to read a copy of the current HIPAA Privacy Policies for the medical practice of Charles D. Atnip, M.D.

Check one of the following:

- ☐ I have read the new policies.
- ☐ I have declined to read the new policies.

Signature:________________________________________Date:_______________

(Parent, if minor)