Dr. Timothy E. Gordon – Dr. Ralph F. Hamilton
1050 N James Campbell Blvd., Suite 100
Columbia, TN 38401
(931)375-1050 – (800)656-2503
www.columbiaeye.net

Dear Patient:

We appreciate the opportunity to see you for examination regarding your complete eye care. We have an appointment scheduled for you on:

_____ at _____ with Dr. _____.

First visits will take approximately one hour. Dilation of your eyes will likely 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.

At the time of your appointment, please bring your current eye glasses, contact lens or eye drops/medication. We will need your current insurance card(s). Also, federal government regulation requires our office to obtain a copy of your current driver's license or other identifying photo ID.

The refraction fee* as well as your co-pay is required at the time of service. Payment in full is required for private pay patients.

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

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

***REFRACTION** Frequently Asked Questions:

- What is refraction?
- Will my insurance pay for 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 or contact lenses.
Most medical insurance plans do not cover routine fractions 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 plan pay for the refraction, you will be refunded accordingly.

PATIENT INFORMATION

(Please Print)

DATE _____

NAME: _____ **M / F** _____ **AGE** _____

DATE OF BIRTH: ____/____/_____ **SOC SECURITY #**_____-_____-_____

MARITIAL STATUS: ____SINGLE ____MARRIED ____WIDOWED ___DIVORCED

ADDRESS _____

STREET CITY STATE ZIP

HOME PHONE : (____)_____ **CELL:** (____)_____

Area code Area code

EMAIL: _____

EMPLOYER_____ **WORK PHONE**_____

SPOUSE_____**DATE OF BIRTH**_____ **SOC SECURITY #**_____

EMPLOYER_____**PHONE**_____

EMERGENCY CONTACT (NEAREST RELATIVE/FRIEND):

NAME_____RELATIONSHIP_____

HOME PHONE_____ CELL_____WORK_____

COMPLETE IF PATIENT IS UNDER 18 OR STUDENT AGE 26 OR UNDER:

1) Responsible Party _____ **Date of Birth**_____

Social Security #_____ **Employer**_____

2) Responsible Party_____ **Date of Birth**_____

Social Security # _____ **Employer** _____

FINANCIAL ASSIGNMENT AND AGREEMENT: We are happy to file insurance as a courtesy to our patients. Please remember your insurance is considered a method of reimbursing your physician and is not a substitute for payment. Accounts not paid within 90 days from the time of treatment may be placed with an outside collection agency.

Please read, initial and sign:

X_____I understand I am financially responsible for all charges.

X_____I request payment to Drs. Gordon and Hamilton of authorized Medicare and/or insurance benefits made on my behalf for any services furnished me. I authorize any holder of medical information about me released 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. 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 hereby authorize said assignee to release all information necessary to secure the payment.

X_____Drs. Gordon and Hamilton reserve the right to refer unpaid past due balances to third parties for collection. In the event any past due balance is placed with a third party for collection, I agree to pay any costs of such collection including agency fees, legal/attorney fees, and court costs.

SIGNATURE X_____DATE_____

(PATIENT, RESPONSIBLE PARTY, GUARDIAN, POA)

DATE_____

PATIENT NAME: _____

RACE: African American or Black_____ Caucasian or White_____ Hispanic_____

Asian_____ Other_____ Decline to Specify_____

ETHNIC GROUP: NOT Hispanic/Latino_____ Hispanic/Latino_____ Decline to Specify_____

PRIMARY CARE DOCTOR:_____ **REFERRED BY:**_____

PHARMACY: Your pharmacy?____ _____ **LOCATION:**_____

ALLERGIES: Do you have **ALLERGIES** to drugs and/or food? Yes_____ No_____

PLEASE **LIST ANY ALLERGIES** and REACTION to
(**DRUGS**/FOOD/SEASONAL)_____

_____

PNEUMONIA VACCINE: **Have you had the pneumonia vaccine: Yes**_____ **No**_____

SMOKING STATUS: Current Smoker_____ Former Smoker_____ Never Smoked_____

FAMILY MEDICAL HISTORY

Do you have a **family history** of **diabetes**? _____Yes _____No

Family member: _____Mother _____Father _____Sister _____Brother

Do you have a **family history** of **glaucoma**? _____ Yes _____No

Family member: _____Mother _____Father _____Sister _____Brother

Do you have a **family history** of **other eye disease**? _____Yes _____ No

Eye Disease_____ Family member: ____Mother ___Father ___Sister ____Brother

Do you have a **family history** of **heart disease**? _____Yes _____No

Family member: _____Mother _____Father _____Sister _____Brother

Other **family history** _____

DO YOU HAVE A HISTORY OF :

_____ANXIETY

_____ARTHRITIS

_____ASTHMA

_____IRREGULAR HEARTBEAT

_____BONE MARROW TRANSPLANT

_____COPD OR LUNG DISEASE

_____CORONARY ARTERY DISEASE

_____DEPRESSION

_____DIABETES

_____END STAGE RENAL DISEASE

_____GERD

_____HEARING LOSS

_____HEPATITIS

_____HIV / AIDS

_____HIGH BLOOD PRESSURE

_____HIGH CHOLESTEROL

_____HYPER/ HYPO THYROIDISM

_____LEUKEMIA

_____LYMPHOMA

_____PROSTATE PROBLEMS

_____SEIZURES

_____STROKE

_____ CANCER OF _____

_____ CHEMOTHERAPY _____RADIATION TREATMENT

OTHER SERIOUS ILLNESS_____

_____

_____

PAST SURGERIES & APPROXIMATE DATES:

(PLEASE **SPECIFY LEFT OR RIGHT** IF INDICATED)

_____

_____

_____

_____

MEDICATIONS:

PLEASE LIST ALL CURRENT **PRESCRIBED** & **OVER THE COUNTER** MEDICINES
OR GIVE A LIST OF YOUR MEDICATIONS TO THE RECEPTIONIST.

NAME OF **MEDICINE**	**DOSAGE**	NAME OF **MEDICINE**	**DOSAGE**

EYE HISTORY

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

Do you wear glasses? **Yes**_____ **No** _____ **How old are your glasses?**_____

Do you wear contact lenses? Yes_____ **No**_____

PAST EYE INJURY? Yes____ No____ IF YES, **WHICH EYE, TYPE OF INJURY, AND WHEN:**

_____

PAST EYE SURGERY? Yes____ No____

IF YES, WHICH EYE, TYPE OF SURGERY AND WHEN :_____

_____

CATARACTS? **Yes**_____ **No**____

GLAUCOMA? **YES**____ **NO**_____

DRY EYES? **Yes**_____ **No**_____

MACULAR DEGENERATION? YES____ **NO**_____

RETINAL DETACHMENT? **YES**____ **NO**____

OTHER EYE PROBLEMS:_____

_____