PATIENT REGISTRATION

Patient_____ Date_____

Address_____

City State Zip

Home Phone_____ Work Phone_____

Cell Phone_____ Text ☐ Yes ☐ No Sex ☐ M ☐ F

Birthdate_____ Age_____ Social Security Number_____

Email _____

Employer_____ Race ☐ Caucasian ☐ African American

Referred By _____ ☐ Hispanic ☐ Asian ☐ Other

IN CASE OF EMERGENCY

Name_____ Relationship_____

Home Phone_____ Work Phone_____

FINANCIAL RESPONSIBILITY

Who is responsible for this account?_____ Birthdate_____

Relation to patient_____ Social Security Number_____

The responsible party is responsible for payment in full of all services or charges rendered by Joslin Eye Center, P.C. reguardless of insurance coverage. Please remember that most insurance companies do not cover all charges in full. Since insurance is a contract between you and your employer or you and the insurance company, you are responsible for any balance for services rendered regardless of any insurance coverage you may have. In the event this account becomes delinquent, the undersigned agrees to pay any necessary collection fees/attorney fees of **no less than 40% added to the unpaid balance**, and court costs.

_____

Responsible Party Signature Date

ASSIGNMENT AND RELEASE

I assign all insurance benefits for services rendered, payable directly to Joslin Eye Center, P.C. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorized the use of this signature on all insurance submissions.

_____

Responsible Party Signature Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have read a copy of the NOTICE OF PRIVACY PRACTICES of Joslin Eye Center, P.C. I understand that signing this acknowledgement is not a requirement to receive treatment by Joslin Eye Center, P.C.

_____

Responsible Party Signature Date

_____ _____ _____ _____ _____

PLEASE TURN OVER TO COMPLETE SIDE 2

MEDICAL HISTORY QUESTIONNAIRE • PAST PERSONAL HISTORY

MEDICATIONS

- _____
- _____
- _____
- _____
- _____
- _____

DRUG ALLERGIES_____

Primary Care Physician_____

Previous Eye Doctor_____

Last Eye Exam_____

Describe all serious illnesses, injuries and surgeries you have had in the past:_____

_____

FAMILY HISTORY

Please note any family member with the following diseases/conditions

M-Mother **F**-Father **S**-Sibling **GP**-Grandparent

	YES	NO		YES	NO
Arthritis _____	☐	☐	Diabetes_____	☐	☐
Blindness _____	☐	☐	Glaucoma _____	☐	☐
Cancer _____	☐	☐	Heart Disease _____	☐	☐
Cataracts _____	☐	☐	Hypertension _____	☐	☐
Crossed Eyes _____	☐	☐	Retinal Disease _____	☐	☐

SOCIAL HISTORY

Check which substances you use and consumption

Alcohol ☐ YES ☐ NO Quantity:_____

Drugs ☐ YES ☐ NO Quantity:_____

Tobacco ☐ YES ☐ NO Quantity: _____

REVIEW OF SYSTEMS

Check the symptoms and/or conditions you currently have

EYES	YES	NO	?
Blurred Vision	☐	☐	☐
Burning	☐	☐	☐
Cataracts	☐	☐	☐
Crossed Eyes	☐	☐	☐
Distorted Vision (Halos)	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Flashes/Floaters in vision	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Glaucoma	☐	☐	☐
Infection of Eye or Lid	☐	☐	☐
Itching	☐	☐	☐
Lazy Eye	☐	☐	☐
Loss of Vision	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Retinal Disease	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Styes or Chalazion	☐	☐	☐
BONE/JOINT/MUSCLE			
Arthritis	☐	☐	☐
Joint/Muscle Pain	☐	☐	☐
Polio	☐	☐	☐
CANCER	☐	☐	☐
ENDOCRINE			
Thyroid Abnormalities	☐	☐	☐
EAR, NOSE, AND THROAT			
Allergies	☐	☐	☐
Chronic Cough	☐	☐	☐
Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐

	YES	NO	?
GASTROINTESTINAL (Stomach)	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
Eczema	☐	☐	☐
Psoriasis	☐	☐	☐
LYMPHATIC/HEMATOLOGIC			
AIDS	☐	☐	☐
Anemia	☐	☐	☐
Bleeding Disorders	☐	☐	☐
Hepatitis	☐	☐	☐
HIV Positive	☐	☐	☐
Liver Disease	☐	☐	☐
Kidney Disease	☐	☐	☐
NEUROLOGIC			
Epilepsy	☐	☐	☐
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Seizures	☐	☐	☐
PSYCHIATRIC			
Depression	☐	☐	☐
High Anxiety	☐	☐	☐
REPRODUCTIVE			
Pregnant/Nursing	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Pneumonia	☐	☐	☐
Tuberculosis	☐	☐	☐
VASCULAR			
Diabetes	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Stroke	☐	☐	☐
Heart Disease	☐	☐	☐

List any other health conditions not mentioned above_____

Doctors Signature_____ Date_____

Dr. Brian Joslin
Dr. Bryce Joslin
Optometrists

Drs. Joslin & Joslin EYE CENTER

125 Peacock Court
Seymour, TN 37865
(865) 577-2002
Fax (865) 577-2046

WELCOME TO THE 21ST CENTURY

Dear Patient,

A new, highly sophisticated computerized instrument now allows us to provide you with a more thorough medical analysis of your eye. The digital retinal imaging system takes images of the retina (the back of your eye), and other structures inside the eye. This procedure assists the doctor in the early detection of many disorders, including glaucoma, diabetic retinopathy, macular degeneration, retinal detachments and other vision threatening conditions. **The images will be stored in the computer and compared with images from future exams. This allows the doctor to observe even the smallest amount of change from the previous procedure.** This procedure does not take the place of dilation.

The doctor strongly recommends that **all patients** have this procedure performed. It is especially important for people who have:

1) Headaches
2) See spots or flashes
3) Family history of diabetes
4) Family history of glaucoma
5) Family history of high blood pressure
6) High cholesterol
7) Reached the age of 40
8) Experienced sudden vision changes
9) New Patients
10) Patients who have never had the procedure

There is an additional charge of $35.00 for this procedure. If a diagnosis is made during your examination, additional imaging may be done and insurance will cover this part of the procedure. Please check the appropriate line below and sign at the bottom.

_____ **I DO** want the procedure performed. Date_____

_____ **I DO NOT** want the procedure performed. Date_____

Signature_____