PATIENT REGISTRATION

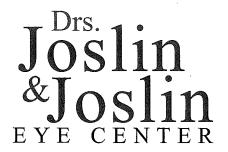
Patient		Date	_	
Address				
Tidal Coo_	City	State	Zip	
Home Phone	Work Phone		*	
Cell PhoneText \square Yes \square No	Sex □ M □ F			
BirthdateAge	Social Security Num	nber		
Email				
Employer	Race Caucasian	☐ African A	merican	
Referred By	☐ Hispanic	☐ Asian	□ Other	
IN CASE O	F EMERGENCY			
Name	ame			
Home Phone	Work Phone			
FINANCIAL	RESPONSIBILITY			
Who is responsible for this account?		Birthdate_		
Relation to patient	Social Security Num	nber		
becomes delinquent, the undersigned agrees to pay any n added to the unpaid balance, and court costs.				
Responsible Party Signature		Date		
ASSIGNMEN	T AND RELEASE			
I assign all insurance benefits for services rendered, paya doctor to release all information necessary to secure payr insurance submissions.	nent of benefits. I authorized			
Responsible Party Signature		Date		
ACKNOWLEDGMENT OF RECEIP? By signing below, I acknowledge that I have read a copy Center, P.C. I understand that signing this acknowledgem Center, P.C.	of the NOTICE OF PR	IVACY PRA	CTICES of Joslin Eye	
Responsible Party Signature		Date		

MEDICAL HISTORY QUESTIONNAIRE • PAST PERSONAL HISTORY

MEDICATIONS					DRUG ALLERGIES Primary Care Physician Previous Eye Doctor Last Eye Exam					
Describe all serious illness	ses, inju	ries and	surgeries	you have had in th	ne past:					
FAMILY HISTO									L HIST	
Please note any family me										you use and consumption
M-Mother F-Fath			oling	GP-Grandparen		NO				Quantity:
A of the	YES	NO	D: 1		YES	NO				Quantity:
Arthritis	- 📙			tes			Tobacco	o∐ YES	□ NO	Quantity:
Blindness	- 📙			oma						
Cancer				Disease						
Cataracts				tension						
Crossed Eyes	_ ∐		Retina	l Disease	[]					
		Cl.	ole tha a	REVIEW			lu barra			
EYES	YES	NO	-	mptoms and/or cor	iuitions y	ou current	iy nave	YES	NO	9
Blurred Vision			? □	GASTROINTE	STINA	[(Stomes	h)	LES		?
Burning				INTEGUMEN'			.ı. <i>j</i>			
Cataracts				Eczema	IAKI (okiii)		_		_
Crossed Eyes				Psoriasis						
-					TIENAAT	roi ocid	,	Ц		
Distorted Vision (Halos)	_			LYMPHATIC/	HEMA	OLOGIC		П	п	П
Double Vision				AIDS						
Dryness				Anemia						
Excess Tearing/Watering	_			Bleeding Disord	iers					
Eye Pain or Soreness				Hepatitis						
Flashes/Floaters in vision	_			HIV Positive						
Foreign Body Sensation				Liver Disease						
Glare/Light Sensitivity				Kidney Disease						
Glaucoma				NEUROLOGI	C					
Infection of Eye or Lid				Epilepsy						
Itching				Headaches						
Lazy Eye				Migraines						
Loss of Vision				Multiple Scleros	sis					
Mucous Discharge				Seizures						
Redness				PSYCHIATRI	C					
Retinal Disease				Depression						
Sandy or Gritty Feeling				High Anxiety						
Styes or Chalazion				REPRODUCT	IVE					
BONE/JOINT/MUSCLE				Pregnant/Nursin	ng					
Arthritis				RESPIRATOR	Ϋ́					
Joint/Muscle Pain		Ō	Ō	Asthma						
Polio		Ō	Ō	Chronic Bronch	itis			Ō	Ō	
CANCER		Ō	Ō	Emphysema				Ō	Ō	
ENDOCRINE	_]	_	Pneumonia						
Thyroid Abnormalities				Tuberculosis						
EAR, NOSE, AND THR	_	J	_	VASCULAR				_		
Allergies				Diabetes						
Chronic Cough		Ö		High Blood Pres	ssure					
Hay Fever		Ö		High Cholestero						
Sinus Congestion				Stroke						
Zinao Congonon		П	П	Heart Disease						
List any other health cond	itions n	ot menti	oned abov							<u> </u>

Doctors Signature_______Date_____

Dr. Brian Joslin Dr. Bryce Joslin Optometrists



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_		