WINSTON EYE & VISION CENTER
8609 Kingston Pike • Suite 101 • Knoxville, TN 37923

PATIENT'S NAME: LAST _____ **FIRST** _____ **MI** _____

HOME ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE: HOME _____ **WORK** _____ **CELL** _____

EMAIL _____ **GENDER: MALE / FEMALE** **BIRTHDATE** ____/____/____

SSN# ____-____-____ **OCCUPATION** _____

EMPLOYER _____

SPOUSE'S NAME: LAST _____ **FIRST** _____ **MI** _____

SPOUSE'S BIRTHDATE ____/____/____ **SPOUSE'S SSN#** ____-____-____

SPOUSE'S EMPLOYER _____ **SPOUSE'S PHONE** _____

EMERGENCY CONTACT INFORMATION: NAME _____

RELATIONSHIP _____ **PHONE NUMBERS** _____

IF PATIENT IS A MINOR, PLEASE GIVE PARENT/GUARDIAN INFORMATION: NAME _____

EMPLOYER _____ **PHONE** _____

REFERRED TO OUR OFFICE BY _____

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY _____ **INSURED'S NAME** _____

INSURANCE ID NUMBER _____ **INSURED'S DATE OF BIRTH** _____

SECONDARY INSURANCE COMPANY _____ **INSURED'S NAME** _____

INSURANCE ID NUMBER _____ **INSURED'S DATE OF BIRTH** _____

ASSIGNMENT AND RELEASE OF BENEFITS:

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ **And assign directly to Winston Eye and Vision Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.**

_____ _____

Responsible Party Signature **Date**

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits be made on my behalf to Winston Eye and Vision Center for services furnished to me by Winston Eye. I authorize any holder of medical information about me to release to the Division of Medicare and Medicaid Services and its agents any information needed to determine those benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature **Date**

PAST PERSONAL HISTORY

List Current Medications:

…… ……

…… ……

…… ……

Drug Allergies: ……..

Primary Care Physician Information:

Name: ……

Phone: ……

Location: ……

List Serious Illness/Surgeries: ……

Are you currently pregnant or a nursing mother? Y / N ……..

FAMILY HISTORY

Arthritis	Y /N	Diabetes	Y / N
Blindness	Y / N	Glaucoma	Y / N
Cancer	Y / N	Heart Disease	Y / N
Cataracts	Y / N	Hypertension	Y / N
Crossed Eyes	Y / N	Retinal Disease	Y / N

SOCIAL HISTORY

Alcohol Y / N	**Circle Hobbies:**
Quantity: ……..	Fishing / Golf
Drugs Y / N	Reading / Hunting
Tobacco Y / N	Computer / Music
Quantity: ……..	Bowling / Sewing

REVIEW OF SYSTEMS

Please check the symptoms and/or conditions you currently have or have had in the past

EYES	**YES**	**NO**	**UNKNOWN**
Blurred Vision	☐	☐	☐
Burning	☐	☐	☐
Cataracts	☐	☐	☐
Crossed Eyes / Lazy Eye	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Eye Pain/Soreness	☐	☐	☐
Flashes/Floaters	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Glaucoma	☐	☐	☐
Infection of Eye or Lid	☐	☐	☐
Itching	☐	☐	☐
Loss of Vision	☐	☐	☐
Sandy/Gritty Feeling	☐	☐	☐
Styes	☐	☐	☐
BONE/JOINT/MUSCLE			
Arthritis	☐	☐	☐
Joint/Muscle Pain	☐	☐	☐
CANCER			
Breast	☐	☐	☐
Lung	☐	☐	☐
Other	☐	☐	☐
CONSTITUTIONAL			
Fever	☐	☐	☐
Sudden Weight Gain/Loss	☐	☐	☐
ENDOCRINE			
Thyroid Abnomalities	☐	☐	☐

EAR, NOSE AND THROAT	**YES**	**NO**	**UNKNOWN**
Allergies	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Mouth	☐	☐	☐
Congestion	☐	☐	☐
GASTROINTESTINAL			
Constipation	☐	☐	☐
Ulcers	☐	☐	☐
INTEGUMENTARY (SKIN)			
Eczema	☐	☐	☐
Psoriasis	☐	☐	☐
LYMPHATIC/HEMATOLOGIC			
AIDS	☐	☐	☐
Anemia	☐	☐	☐
Herpes	☐	☐	☐
NEUROLOGIC / PSYCHIATRIC			
Epilepsy	☐	☐	☐
Headaches	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Seizures	☐	☐	☐
High Anxiety	☐	☐	☐
Depression	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Tuberculosis	☐	☐	☐
VASCULAR			
Diabetes	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Stroke / Heart Disease	☐	☐	☐

Reviewed by: Dr. J / Dr. B / Dr. S Date: …./…./…. …./…./…. …./…./…. …./…./…. …./…./…. …./…./…. …./…./….