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TENNESSEE RETINA
(615) 983-6000

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Registration Information

l) Please complete the following forms PRIOR to your visit.
* Patient Medical History
* Patient Consent for Use & Disclosure of Protected Health Information
* If you have a separate medicine list and/or your own printed medical history summary, please bring a copy for our records.

2) Our staff may contact you for a phone interview in advance of your appointment.
This will allow us to gather your patient information from the above forms prior to your arrival.
*If you are unable to do the interview in advance, please bring the **completed forms** to your first office visit.*

3) Sign in at our reception desk. Please bring a photo ID and your medical insurance card(s).
If your insurance requires a referral, it is your responsibility to obtain this from your primary care doctor or referring physician prior to your appointment.

What to expect

Your visit may last one to three hours, depending on the complexity of your problem, type of testing required, or if immediate treatment is needed. We will dilate your pupils to perform a thorough retinal exam. Side effects include blurred vision and light sensitivity, which may last several hours. We recommend you have transportation arranged for your trip home.

Payment Information

If your insurance company requires a co-payment, this is due upon registration, prior to your exam. We accept cash, checks, VISA/MASTERCARD/DISCOVER. If you are uninsured, please call our office PRIOR to your visit, so our patient account specialist can review our policies with you.

Your appointment information is as follows: _____ has an appointment with

Dr._____ on ____/____/____ at _____:_____ AM/PM at the location checked below

☐ **MAIN OFFICE @ Centennial Professional Plaza**
345 23rd Avenue North, Suite 350
Nashville, TN 37203
615.983.6000 / 983.6010 (fax)

☐ **Cookeville @ Eye Institute of Cookeville**
1125 Perimeter Park Drive, Suite 300
Cookeville, TN 38501

☐ **Hendersonville @ Physicians Plaza**
100 Springhouse Court, Suite 240
Hendersonville, TN 37075

☐ **Clarksville @ Chesapeake Center**
141 Chesapeake Lane, Suite 201
Clarksville, TN 37043

☐ **Crossville @ Cumberland Eye Care**
39 Lantana Road
Crossville, TN 38555

☐ **Murfreesboro @ Murfreesboro Medical Clinic North Entrance**
1272 Garrison Drive, Suite 306
Murfreesboro, TN 37219

☐ **Columbia @ Columbia Eye Associates**
1050 North James Campbell Blvd.
Columbia, TN 38401

☐ **Franklin @ Physicians Plaza**
100 Covey Drive, Suite 107
Franklin, TN 37067

☐ **Kentucky Office | Bowling Green**
1332 Andrea Street
Bowling Green, KY 42104

For directions to any of our office locations, and to learn more about us, please visit our website at www.TNRETINA.com

TENNESSEE RETINA

PATIENT MEDICAL HISTORY

Name: ☐Mrs. ☐Ms. ☐Miss ☐Mr. _____Date:_____

Address:_____

City:_____State:_____Zip:_____Date of Birth:_____

Have you had any of the following? (explain YES answers below)

Laser eye surgery..... ❒Yes ❒No _____

Cataract surgery..... ❒Yes ❒No _____

Retina surgery..... ❒Yes ❒No _____

Eye Infections..... ❒Yes ❒No _____

Glaucoma ..... ❒Yes ❒No _____

Other eye problems/surgery..... ❒Yes ❒No _____

Do you have any of the following conditions?

Anemia..... ❒Yes ❒No

Arthritis ..... ❒Yes ❒No

Headache ..... ❒Yes ❒No

Hearing loss..... ❒Yes ❒No

Liver disease..... ❒Yes ❒No

Sinus trouble..... ❒Yes ❒No

Fever or chills..... ❒Yes ❒No

Thyroid disease ... ❒Yes ❒No

Kidney problem ..... ❒Yes ❒No

Back or neck pain ..... ❒Yes ❒No

Bleeding disorder..... ❒Yes ❒No

Dementia/Alzheimers..... ❒Yes ❒No

Recent weight change..... ❒Yes ❒No

Rash or skin problems ..... ❒Yes ❒No

Mouth sores or disease ..... ❒Yes ❒No

Fatigue/overall weakness.. ❒Yes ❒No

Difficulty with urination..... ❒Yes ❒No

Chest pain/palpitations..... ❒Yes ❒No

Cough/shortness of breath..... ❒Yes ❒No

Stomach/intestinal problem ..... ❒Yes ❒No

Depression/psychiatric problem ..... ❒Yes ❒No

Numbness/tingling in fingers/toes..... ❒Yes ❒No

Mobility issues/Physical Limitations.... ❒Yes ❒No

		date of onset
Autoimmune Conditions..... ❒Yes ❒No	_____	_____
Infectious disease..... ❒Yes ❒No	_____	_____
(HIV, AIDS, Hepatitis, Meningitis, MRSA, Shingles, Staph, TB)		
High blood pressure..... ❒Yes ❒No	_____	_____
Diabetes..... ❒Yes ❒No ..... ❒Type I ❒Type II	_____	_____
Lung disease ..... ❒Yes ❒No	_____	_____
High cholesterol..... ❒Yes ❒No	_____	_____
Cancer..... ❒Yes ❒No	_____	_____
Stroke/neurologic disorder..... ❒Yes ❒No	_____	_____
Heart disease ..... ❒Yes ❒No	_____	_____

Have you had any recent travels outside of the continental United States within the last year? ❒Yes ❒No

Where_____

Date of recent physical examination: _____

Primary care physician: _____

City: _____ State:_____

(continue on other side)

List any other major illnesses, hospitalization and surgeries (with dates, if possible):

_____

_____

_____

_____

List all medications you currently take (name, dosage, frequency). If none, check here ❒.

Eye medications: _____

_____

Other medications: _____

_____

_____

Are you allergic to any medications? ❒**Yes** ❒**No** (If YES, please list)

_____

_____

_____

Have any family members or relatives had any of the following conditions? (list relationship to you below)

Glaucoma ..... ❒Yes ❒No _____

Macular degeneration ..... ❒Yes ❒No _____

Retinal detachment ..... ❒Yes ❒No _____

Diabetic Retinopathy ..... ❒Yes ❒No _____

Blindness ..... ❒Yes ❒No _____

Diabetes ..... ❒Yes ❒No _____

Heart disease ..... ❒Yes ❒No _____

Cancer ..... ❒Yes ❒No _____

Uveitis ..... ❒Yes ❒No _____

Autoimmune Conditions ..... ❒Yes ❒No _____

Your occupation: _____ Retired ❒

Your employer: _____

Marital Status: ..... ❒Married ❒Single ❒Widow(er)

Do you drive a car?: ..... ❒Yes ❒No

Can you read small print (newsprint)? ..... ❒Yes ❒No

Do you smoke tobacco? ..... ❒Yes ❒No Current or previous use? _____

Do you drink alcohol? ..... ❒Yes ❒No How often? _____

History of drug/substance abuse: ..... ❒Yes ❒No Details _____

_____

TENNESSEE RETINA

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I received, read and understand your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time to obtain a current copy of the ***Notice of Privacy Practices.***

Signature of Patient or Legal Guardian:_____Date:_____

Print Patient's Name:_____

Print Legal Guardian's Name:_____

Consent to Release Information

I designate the following representative(s) who the doctor or clinical staff can communicate with on my behalf. If I do not designate anyone, I understand that the doctor or clinical staff will be unable to speak with anyone regarding my medical condition.

Name:_____Relationship:_____Phone #:_____

Name:_____Relationship:_____Phone #:_____

Name:_____Relationship:_____Phone #:_____

Signature on File:

Signature of Patient or Legal Guardian:_____ Date:_____

Print Patient's Name:_____

Print Legal Guardian's Name:_____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the ***Notice of Privacy Practices*** Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason:
