Hendersonville Eye Health & Vision, PLLC

Welcome to our office!

Today's Date _____
Name_____
Is this your first exam at our office? Yes ☐ No ☐
Date of Birth _____ / _____ / _____ Sex M ☐ F ☐
Street_____
City_____ State _____ Zip_____
Social Security # _____
Occupation (or grade) _____
Cell Phone _____
Home Phone _____
Email _____

Reason for Visit? (Check all that apply):

General exam ☐ Glasses ☐
Red eye/pain ☐ Contacts ☐
Blurred Vision ☐ Double Vision ☐
Bothersome light Glare or Sensitivity ☐
Other:

_____
_____
_____

Medications

Please list any Medications you take, including oral contraceptives, aspirin, over the counter medications and home remedies

_____
_____
_____
_____

Allergies

Please list any known allergies

_____
_____
_____
_____

Are you pregnant or nursing? Yes _____ No _____

Name of Medical Doctor _____
Location of Medical Doctor
_____
_____
Emergency Contact _____
Relationship _____
Phone number _____

Preferred method of contact
Voice Call ☐
Text ☐
Email ☐

Eye Conditions

Have you ever been diagnosed with the following?
(Please check the conditions that apply to you)

Cataract ☐
Age-related Macular Degeneration ☐
Glaucoma ☐
Diabetes ☐
Diabetic Retinopathy ☐
Dry Eye ☐
Eye infection, inflammation, or allergy ☐
Floaters and/or flashes of light ☐
Iritis or Uveitis ☐
Retina defects or degenerations ☐

Please list any additional conditions/comments
_____
_____

Social History

Tobacco use? Yes _____ No _____
If yes, type / how long? _____

Do you drink alcohol more than occasionally?
Yes ____ No ____ If yes, how much? _____

If referred to our practice, who might we can thank for referring you? _____

Please Complete Page 2

Personal Medical History - Do you currently, or have you ever had any problems in the following areas:

ENT
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis

Neurological
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Stroke/CVA
- ☐ MS
- ☐ Migraine
- ☐ Epilepsy
- ☐ Autism Spectrum

Constitutional
- ☐ Extreme fatigue
- ☐ Weight loss/gain

Psychiatric
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Anxiety Disorder
- ☐ Attention Deficit

Cardiovascular
- ☐ Hypertension
- ☐ Stroke/CVA
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Heart Failure

Respiratory
- ☐ Cigarette Smoker
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Sleep Apnea

Genitourinary
- ☐ Pregnant
- ☐ Nursing
- ☐ Prostate Cancer
- ☐ STD
- ☐ Chlamydia
- ☐ Herpes
- ☐ Kidney Disease

Musculoskeletal
- ☐ Osteoarthritis
- ☐ Arthritis
- ☐ Muscular Dyst
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Gout

Integumentary
- ☐ Shingles
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Cold Sores

Endocrine
- ☐ Thyroid Dysf
- ☐ Hormonal Dysf
- ☐ Type 2 Diabetes
- ☐ Type 1 Diabetes

Hematologic/Lymphatic
- ☐ Ulcer
- ☐ Blood Loss
- ☐ Anemia
- ☐ High Cholesterol

Allergic/Immune
- ☐ Drug Allergies
- ☐ Environmental Allergies
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjogren's Syndrome

Family Medical History – Please check all that apply

☐ Thyroid	☐ Diabetes	☐ Glaucoma Suspect	☐ Severe Myopia	☐ Retinal Detachment
☐ Hypertension	☐ Cataract	☐ Macular Degeneration	☐ Severe Hyperopia	☐ Dry Eye
☐Cancer	☐ Glaucoma	☐ Amblyopia	☐ Strabismus	☐ Nystagmus

Your Attention Please:

To evaluate your eyes for diseases and defects such as glaucoma, melanoma (cancer), macular degeneration, and retinal detachment, Dr. Garnsey must examine and monitor the back of your eyes annually. Dr. Garnsey recommends using the Optomap for this evaluation.

Please **choose one** of the following options for the most important part of your exam:

☐ **Optomap** - ($25) The latest retinal imaging technology available. Painless/Drug-Free/Recommended

☐ My internal eye health doesn't concern me today. I agree to sign a waiver to decline this important evaluation.

Agreement: The below signature signifies that I have completed and/or reviewed the information on this history form and agree it is accurate and up-to-date. I also agree to and understand the **Payment Policy, Notice of Privacy Practices Acknowledgement, Contact Lens fit agreement and Eyeglass Warranty** information which is located on the back of this page or attached as a third page.

_____ _____

Patient Signature or Parent Guardian Signature Date

_____ _____

Payment Policy:

1) You are agreeing that if your payment for services and/or materials rendered is ever uncollectable (i.e. returned check or lapse of insurance coverage), you will be responsible for payment of any and all collection costs. You hereby agree to assume the responsibility of any remaining copayment and balances after payment is made that are not covered by your insurance. You hereby authorize release of any information with respect to your claim and certify that the information furnished in support of the claim is true and correct.
2) You are authorizing Hendersonville Eye Health & Vision, PLLC to disclose your name, address, telephone #, appointment dates and time for the purpose of recalling lists to remind you of your next appointment time and to provide you with product information.

Notice of Privacy Practices Acknowledgement:

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

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

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I understand that I may request, in writing, that you restrict how my private information is used to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Late Policy:

If a patient is more than 15 minutes late for an appointment, the appointment may need to be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers as best as possible, but cannot compromise on the quality and timely care provided to our other patients.

Eyeglass Warranty:

I understand that in rare cases my eyeglass prescription may need to be tweaked after my eyeglasses are made. If I experience any discomfort or blur that lasts longer than a week of continual wear, Hendersonville Eye Health and Vision will be happy to re-evaluate my prescription to see if any changes need to be made to the prescription and re-make my updated lenses for free. I have **60** days from the date of **purchase** to contact the office. If I contact Hendersonville Eye Health and Vision after the 60 day mark, I will be responsible for the cost of any adjustments to my lenses. Please visit our website for additional details.

Contact Lenses Fitting Fee Agreement:

I understand that contacts are as unique as the patient wearing them. Because of this, if my prescription requires a little extra attention or extended parameters, I may be subject to an advanced fitting fee. This fee is still billable to my insurance but may be a little higher than that of a standard fit. Dr. Garnsey will assess my prescription to determine if this is necessary.