Pilkinton™
EYE CENTER

Thank you for choosing **Pilkinton Eye Center.** We are glad for the opportunity to serve you. Please read this cover letter and complete the registration forms.

Registration Form: In order for your insurance to pay your claim, a registration form will need to be completed annually, even if you are an established patient, or more often if there are changes in your health history. Be sure to include a current list of your medication, including dosages (mg).

Refraction: An eye refraction is necessary if you have a complaint of blurred or decreased vision or a glasses prescription is needed.

What to Expect: If you are a new patient and may need to schedule surgery, you will most likely be here 2-3 hours. Annual dilated exams may take 1-2 hours. On your new patient or annual exam, you will be dilated in order to perform a thorough retinal exam. Dilation may cause light sensitivity and can last for several hours. You will be given sunglasses and most patients are able to drive themselves home.

Insurance: Since we are a medical provider, we do not participate with vision plans. We participate with most medical insurance plans and we are glad to file up to two (2) insurance plans for you. It is important that you provide us with the correct insurance information. Failure to do so may result in direct billing to you.

Referrals: Some insurance companies require a referral from your primary care physician to see Dr. Pilkinton. If your insurance requires a referral for your visit please initiate this at least 2 weeks in advance of your appointment. It is helpful to call us a few days before your visit to be sure that the referral is here. It is the patient's responsibility to obtain the referral. Have your physician's office fax their referral to (615)329-7892. If you arrive without a referral, we can reschedule your appointment or you may pay for your visit.

Deductibles/Co-pays: Please be prepared to pay your co-pays and unmet deductible the day of your visit. If you schedule surgery, we will look up your benefits for you so that you will be prepared for any out-of-pocket fees, which we will collect before surgery. We accept MasterCard, Visa, Discover, cash, check and Care Credit (6 months same-as-cash and the extended plans).

Optometrist Referrals: If your optometrist referred you to Dr. Pilkinton for cataract surgery, he or she may perform the post-operative care following your surgery (if they participate in your insurance plan). This is called "co-management" and your insurance will pay him or her a portion of your care. For Lasik patients, a portion of the Lasik fee is paid to your optometrist.

Contact Lenses and Glasses: If you wear glasses for most activities, please bring them with you. For patients who are scheduling cataract surgery or Lasik, it is important to discontinue wearing contact lenses for at least two weeks prior to your visit. Please call our office at (615)329-7890.

Skilled Nursing Facility/Hospice: Please notify our office if you are in a Skilled Nursing Facility or Hospice. This determines how your insurance will need to be filed.

Valet Parking is now available from 20th Avenue Entrance to the building. The hours of operation are 7:30 am to 4:00 pm.

Dale Pilkinton, M.D.

300 20th Avenue North

Suite 408

Nashville, TN 37203

615-329-7890

Pilkinton EYE CENTER

300 20th AVENUE NORTH, SUITE 408, NASHVILLE, TN
37203 P: 615-329-7890/F: 615-329-7892

Today's Date: _____

PATIENT DEMOGRAPHICS

_____ _____ _____ _____ _____
(Title) (First Name) (Middle) (Last Name) (Suffix)

Marital Status: _____ Sex: Male/Female

Date of Birth: _____ Age: _____

COMMUNICATIONS

Address: _____ Zip: _____ City: _____ State: _____

County: _____Phone: _____ _____ _____
(Home) (Work) (Cell)

Email: _____

PHYSICIANS & PHARMACY

Referring Physician: _____ Referring Physician Phone: _____

Primary Care Physician: _____ Primary Care Physician Phone: _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

Pharmacy Address: _____

LANGUAGE, ETHNICITY, RACE, & OCCUPATION

Race: **(circle)** White / Black / American Indian, Eskimo or Aleut / Asian or Pacific Islander / Other Race / Unknown

Ethnicity: **(circle)** Hispanic / Not Hispanic / Unknown Language: _____

Employer: _____ Occupation: _____

EMERGENCY CONTACT & SPOUSE

Emergency Contact (**NOT your Spouse**): _____ Relationship: _____ Phone: _____

Spouse: _____ Spouse DOB: _____ Spouse Phone: _____

Height: _____ Weight: _____ (This is needed for the surgery center on patients that may be having surgery.)

**** If you weigh over 380 lbs, please call our office <u>BEFORE</u> your appointment.**

MEDICAL HISTORY

Ocular Health

Please mark any condition **you** presently have or have had in the past:

☐ Dry Eye ☐ Macular Degeneration ☐ Glaucoma
☐ Cataracts ☐ Retinal Detachment ☐ Keratoconus
☐ Other - please explain: _____

Date of your last eye exam: _____ **Doctor/where:** _____

Do you wear glasses? *(YES or NO)* **Do you wear Contacts?** *(YES or NO)* **Brand & Rx:** _____

Family Ocular Health

Please mark any condition **your family members (blood relatives)** presently have or have had in the past and **list their relation to you**:

☐ Cataracts _____ ☐ Keratoconus _____
☐ Dry Eye _____ ☐ Macular Degeneration _____
☐ Glaucoma _____ ☐ Retinal Detachment _____
☐ Other - please explain: _____

General Health

Please mark any condition **you** presently have or have had in the past:

☐ High Blood Pressure ☐ Heart Disease/Problems ☐ Arthritis *(**Circle** Rheumatoid or Osteo)*
☐ Lung Problems ☐ Stroke/CVA ☐ Thyroid Problems
☐ Diabetes *(**Circle** Type 1 or Type 2 and Insulin or Non-Insulin)* ☐ High Cholesterol
☐ Ulcers ☐ Cancer, Type: _____
☐ Other - please explain: _____

Family General Health

Please mark any condition **your family members (blood relatives)** presently have or have had in the past and **list their relation to you**:

☐ High Blood Pressure_____ ☐ Heart Disease/Problems _____
☐ Arthritis _____ ☐ Lung Problems _____
☐ Stroke/CVA _____ ☐ Thyroid Problems _____
☐ Diabetes *(**Circle** Type 1 or Type 2 and Insulin or Non-Insulin)* _____
☐ High Cholesterol _____ ☐ Ulcers _____
☐ Cancer, Type: _____
☐ Other - please explain: _____

Surgical History

Ocular (Eye) Surgeries/Procedures:

Please list any surgeries (LASIK, PRK, Cataract Surgery, Glaucoma Surgery, etc.) you have had, *the date of surgery* and the surgeon.

_____

_____

Bodily Surgeries/Procedures:

Please list the dates

_____

_____

_____

_____

Medications

*****Do you or have you ever taken FLOMAX or any prostate medication? ☐YES ☐NO*****

Ocular (Eye) Medications:

Please list any **prescription or over-the-counter** eye drops/ocular supplements you currently use.

_____

_____

Systemic Medications:

Please list any **prescription or over-the-counter** medications you currently take and the **milligrams/dose**.

_____

_____

_____

_____

_____

_____

Drug/Food Allergies:

Medication, Food, or Latex – please list anything to which you are allergic **& what your reaction was.**

_____

_____

_____

☐**No Known Drug Allergies**

What is the main reason for your visit today?

_____

Are you experiencing:

☐Glare/Light Sensitivity ☐Distorted Vision or Halos ☐Difficulty driving due to Vision ☐Blurry Vision

☐Loss of Side Vision ☐Sudden Vision Loss ☐Floaters (dark spots, spider webs) ☐Flashes of Light

☐Curtains/Veils ☐Excessive Tearing/Discharge ☐Excessive Itching ☐Sandy/Gritty Sensation

☐Eye Pain/Burning ☐ Eye Strain/Tired Eyes ☐Eye Infection ☐History of Uveitis/Iritis

☐Double Vision ☐Amblyopia (Lazy Eye) ☐Drooping Eye Lid ☐History of Eye Trauma

Review of Systems

Please mark any conditions **you currently** have:

***Allergic/Immunologic*:** ☐Hay fever ☐Seasonal Allergies ☐Other _____	***Cardiovascular*:** ☐Chest Pain ☐Congestive Heart Failure ☐High Blood Pressure ☐Irregular Heart beat ☐Low Blood Pressure ☐Pacemaker/Defibrillator ☐Shortness of Breath ☐Other _____
***Constitutional*:** ☐Fatigue ☐Fever ☐Rash ☐Weight Loss ☐Other _____	***Ear, Nose, Mouth & Throat*:** ☐Hearing Loss ☐Dry Mouth ☐Post Nasal Drip ☐Runny Nose ☐Sinus Infection ☐Other _____
Endocrine: ☐Hyperthyroidism ☐Hypothyroidism ☐Polydipsia ☐Mood Swings ☐Other _____	***Eyes*:** ☐Double Vision ☐Eye Pain ☐Vision Loss ☐Other _____
***Gastrointestinal*:** ☐Bloody Stools ☐Constipation ☐Diarrhea ☐Hepatitis ☐Jaundice ☐Ulcers ☐Vomiting ☐GERD/Acid Reflux ☐Other _____	***Genitourinary*:** ☐Blood in Urine ☐Discharge ☐Genital Ulcers ☐Kidney Stones ☐Other _____
***Hemotologic/Lymphatic*:** ☐Anemia ☐Blood Transfusions ☐Excessive Bleeding ☐Infection ☐Purpura ☐HIV/Aids ☐Other _____	***Integumentary*:** ☐Breast Lumps ☐Dermatitis ☐Eczema ☐Rashes ☐Wounds ☐MRSA ☐Other _____
***Musculoskeletal*:** ☐Joint Ache ☐Pain ☐Paralysis ☐Stiffness ☐Swelling ☐Other _____	***Neurological*:** ☐Alzheimer's Disease ☐Dementia ☐Faints ☐Headache ☐Migraines ☐Multiple Sclerosis ☐Numbness ☐Parkinson's Disease ☐Seizures ☐Stroke ☐Neuropathy ☐Other _____
***Psychiatry*:** ☐Anxiety ☐Depression ☐Paranoia ☐Memory Loss ☐Mental and/or Emotional Factors ☐Sleep Patterns ☐Other _____	***Respiratory*:** ☐Asthma ☐Bronchitis ☐COPD ☐Cough ☐Emphysema ☐Shortness of Breath ☐TB ☐Sleep Apnea/CPAP ☐Use Oxygen ☐Other_____

Social History

Have you had the Flu Vaccine? **(YES or NO)** Have you had the Pneumonia Vaccine? **(YES or NO)**

Do you smoke? **(YES or NO)** Type: **(Cigarettes/Pipe/Tobacco/Vapor?)** How much per day: _____

Former Smoker? **(YES or NO)** How long have you or did you smoke: _____

Do you drink alcohol? **(YES or NO)** Type: **(Liquor/Beer/Wine?)** Quantity: _____ How often: _____

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FINANCIAL AGREEMENT

Payment Terms:

Pilkinton Eye Center participates with most medical insurance plans. If there are questions about the patient's insurance policy or benefit details, please talk with the medical insurance provider before his/her appointment. It is each patient's responsibility to be familiar with his/her health plan.

Payment is due at the time of service for non-insured services, co-pays, deductibles, and eye refractions. Please call the patient's insurance provider for details such as co-pays and deductibles before your visit.

We will file up to two medical insurance plans. Please know that failure to bring insurance cards to each appointment may result in additional out-of-pocket expenses or appointment rescheduling.

Providing incorrect insurance information may result in direct billing to the patient.

Pilkinton Eye Center does not participate with vision plans.

We do not fit, dispense, or prescribe contact lenses. If the patient chooses to wear contact lenses, we will refer him/her to an optometrist who can assist in those services.

Some insurance plans require a referral from the Primary Care Doctor. It is the patient's responsibility to obtain this referral. Failure to obtain a referral will result in additional out-of-pocket expenses or appointment rescheduling.

Past due accounts will be collected in full before future appointments are made. Questions about the patient's account should be directed to our Billing Department at (615)329-7890.

I acknowledge full responsibility of all services provided for me and agree to pay all expenses, including collection and attorney fees, necessary to collect the balance. I also agree to promptly notify Pilkinton Eye Center of any medical insurance carrier changes or coverage changes. I acknowledge that failure to do so may result in direct billing and monthly late fees.

I hereby request that payment of Medicare, Medigap, or other insurance benefits be made to Pilkinton Eye Center for any services. I authorize any holder of medical information about me to release to the Center for Medicare (CMS), or to my insurer, any information needed to determine these benefits.

Patient Name: _____

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

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HIPAA PATIENT CONSENT FORM

In response to the misuse of Personal Health Information, the *Department of Health and Human Services* has established a **Privacy Rule** to insure that your Personal Health Information is kept private. This rule was also established in order to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient in order to carry out treatment, payment, or other health care operations.

We want you to know that we respect the privacy of your personal medical records and will take all reasonable measures to secure and protect your privacy. When necessary we will provide the minimum necessary information to only those we feel are in need of your Personal Health Information in order to provide health care that is in your best interest.

We support your full access to your medical records. You should be aware that we may have indirect treatment relationships with you that include but are not limited to laboratories, pharmacies, and other medical offices. As such, we may need to disclose your Personal Health Information for purposes of treatment, payment and/or health care operations. These outside entities do not necessarily need to obtain your consent for this communication.

You have the right to refuse to consent to the use of disclosure of your Personal Health Information. This refusal must be made in writing. Under the HIPAA law, we have the right to refuse to treat you if you choose to refuse disclosure of your Personal Health Information. If you give consent to disclose your Personal Health Information, by signing this document, you can at some future time request to refuse future disclosures of your Personal Health Information. This refusal must be made in writing. However, you may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have received a copy of our Patient Privacy Policy. You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Please speak with our administrative staff if you have objections to this consent.

Please list any individual with whom we may discuss your Personal Health Information below (i.e. spouse, family member, friend, etc.):

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Patient Name: _____

Patient Signature: _____ **Date:** _____ **Expires:** _____