BLINK OF AN EYE OPTOMETRY PLLC

Scott Chamberland, OD
119 South Academy St
Murfreesboro, TN 37130
615-893-1913

STEP 1: PATIENT REGRISTRATION

PATIENT_____

ADDRESS_____

_____

_____
CITY STATE ZIP

HOME PHONE NUMBER

_____

WORK PHONE NUMBER

_____

EMAIL ADDRESS

_____

SEX MALE ___ FEMALE___

BIRTH DATE___/___/___

SOCIAL SECURITY NUMBER

_____

AGE____ MARITAL STATUS: S__ M__ W__ D__

OCCUPATION_____

EMPLOYER_____

EMPLOYER ADDRESS_____

_____

SPOUSE'S NAME_____

BIRTHDATE __/___/___

SS#_____

OCCUPATION_____

SPOUSE'S EMPLOYER_____

IN CASE OF AN EMERGENCY:

NAME_____

RELATIONSHIP_____

PHONE NUMBER (H)_____

(W)_____

_____

STEP 2: INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Birthdate___/___/____

Insurance Company_____

Group Number_____

Is Patient covered by additional Insurance? Y____ N_____

Subscriber Name_____

Birthdate___/___/___ SS#_____

Relationship to Patient_____

Insurance Company_____

Group Number_____

ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH_____AND ASSIGN DIRECTLY TO SCOTT CHAMBERLAND OD ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINACIALLY 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 SCOTT CHAMBERLAND OD FOR SERVICES FURNISHED ME BY SCOTT CHAMBERLAND OD. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE DIVISION OF MEDICARE AND MEDICAL SERVICES AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THOSE BENEFITS PAYABLE FOR RELEASED SERVICES. I **UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECCESSARY 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 PHYSCIAN 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

STEP 3: MEDICAL HISTORY QUESTIONNAIRE

PAST PERSONAL HISTORY

MEDICATIONS:_____

_____

_____

_____

DRUG
ALLERGIES:_____

_____

PRIMARY CARE PHYSICIAN INFORMATION

NAME_____ PHONE NUMBER_____

ADDRESS_____ FAX_____

_____

_____

PATIENT HEIGHT_____ WEIGHT_____

DESCRIBE ALL SERIOUS ILLNESSES, INJURIES AND
SURGERIES:_____

_____

_____

_____

BLINK OF AN EYE OPTOMETRY

SCOTT CHAMBERLAND, OD

BONE/JOINT/MUSCLE

	YES	NO
Muscular Dystrophy	___	___
Fibromyalgia	___	___
Osteoporosis	___	___
Osteoarthritis	___	___
Arthritis	___	___
Anklyosing Spondylitis	___	___

EAR/NOSE/THROAT

	YES	NO
Sinus Congestion	___	___
Runny Nose	___	___
Hearing Loss	___	___
Laryngitis	___	___
Chronic Cough	___	___

CANCER

	YES	NO
Breast	___	___
Bone	___	___
Lung	___	___
Skin	___	___
Prostate	___	___

VASCULAR

	YES	NO
Congestive Heart failure	___	___
High Blood Pressure	___	___
Type I Diabetes	___	___
Type II Diabetes	___	___
Vascular Disease	___	___
Stroke	___	___
Heart Disease	___	___

NEUROLOGIC

	YES	NO
Multiple Sclerosis	___	___
Cerebral Palsy	___	___
Headaches	___	___
Migraines	___	___
Epilepsy/Seizures	___	___
Tumor	___	___
Bells Palsy	___	___

RESPIRATORY

	YES	NO
Chronic Bronchitis	___	___
Emphysema	___	___
Sleep Apnea	___	___
Tuberculosis	___	___
COPD	___	___
Asthma	___	___

BLOOD ISSUES/DISORDERS

	YES	NO
Bleeding Disorders	___	___
Liver Disease	___	___
HIV	___	___
Hepatitis	___	___
Anemia	___	___
AIDS	___	___
High Cholestrol	___	___

PSYCHIATRIC

	YES	NO
Hign anxiety	___	___
Depression	___	___
Bi-Polar	___	___
ADHD	___	___
ADD	___	___
Other	___	___

BLINK OF AN EYE OPTOMETRY

SCOTT CHAMBERLAND OD

REPRODUCTIVE

	YES	NO
Currently Pregnant	___	___
Currently Nursing	___	___

GASTROINTESTINAL

	YES	NO
Chrohn's Disease	___	___
Celiac Disease	___	___
Acid Reflux	___	___
Colitis	___	___
Ulcers	___	___

INTEGUMENTARY

	YES	NO
Cold sores	___	___
Shingles	___	___
Psoriasis	___	___
Rosacea	___	___
Eczema	___	___

GENITOURINARY

	YES	NO
Kidney Disease	___	___
Prostate Disease	___	___

CONSTITUIONAL

	YES	NO
Developmental Disabilties	___	___
Sudden Weight Gain/Loss	___	___
Fatigue Syndrome	___	___
Fever	___	___

ENDOCRINE

	YES	NO
Hormonal Dysfuction	___	___
Hypo-Thyroid	___	___
Hyper-Thyroid	___	___
Graves Disease	___	___

ALLERGY/IMMUNE

	YES	NO
Enviromental Allergies	___	___
Drug Allerigies	___	___
Sjorgen's Syndrome	___	___
Lupus	___	___
Hay Fever	___	___

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119 South Academy Street
Murfreesboro, TN 37130
Phone 615-893-1913
Fax 615-893-1917

Medical History Questionaire

Please check the symptoms and/or conditions below that may apply to you.

PERSONAL EYE HISTORY

	YES	NO		YES	NO
Blurred Vision	___	___	Itching	___	___
Burning	___	___	Lazy eye/Amblyopia	___	___
Cataracts	___	___	Loss of Vision	___	___
Crossed eyes	___	___	Styres/Chalazion	___	___
Distorted Vision(Halos)	___	___	Redness	___	___
Double Vision	___	___	Retinal Disease	___	___
Dryness	___	___	Glare/Light Sensitivity	___	___
Excess Tearing/Watering	___	___	Eye or Lid Infection	___	___
Eye Pain or Soreness	___	___	Mucous Discharge	___	___
Flashes/Floaters	___	___	Sandy/Gritty Feeling	___	___
Foreign Body	___	___			
Glaucoma	___	___			

FAMILY HISTORY

Please check "YES" if any family members have the following diseases/ conditions; if "YES" mark "FM" with; M-mother, F-father, S-sister, B-brother, grandparent-GP

	YES	**FM**		**YES**	**FM**		**YES**	**FM**
Arthritis	___	___	Type I Diabetes	___	___	High Blood Pressure	___	___
Blindness	___	___	Type 2 Diabetes	___	___	Heart Disease	___	___
Cancer	___	___	Glaucoma	___	___	Macular Disease	___	___
Catracts	___	___	Hypothyroid	___	___	Retinal Disease	___	___
Crossed eyes	___	___	Hyperthyroid	___	___			

SOCIAL HISTORY

	Yes	**NO**	
Alcohol	___	___	Quantity _____
Tobacco	___	___	Type&Quantity_____
Recreational Drugs	___	___	