SOUTHEASTERN RETINA ASSOCIATES
Diseases and Surgery of the Retina and Vitreous

PLEASE COMPLETE ALL THE ENCLOSED INFORMATION BEFORE ARRIVING FOR YOUR APPOINTMENT. YOU WILL BE DILATED AT EVERY VISIT THEREFORE IT IS ALWAYS RECOMMENDED THAT YOU BRING A DRIVER.

Dear Patient:

We would like to welcome you to Southeastern Retina Associates. Please visit our website www.tennesseeretina.com for more information about our practice, physicians, and various locations in Tennessee and the surrounding states.

Thorough retinal evaluation requires that you spend more time in our office than would be necessary for a general eye examination. During the initial visit, we will ask you questions about your eyes, your general health, and any medications that you take. Collection of medical information and a variety of tests must be performed both before and after dilation of the pupils. Please bring a companion to drive you home after the dilated eye exam.

Please remember that traffic and parking can add to delays at some of the different locations and to allow for additional travel time. If you discover that you are going to be late please call us as soon as possible. We do understand unforeseeable delays may occur. We will try to accommodate the occasional patient who is late, but this may not always be possible without compromising the quality of your care and depriving other patients of their own scheduled appointment times.

Thank you,
Southeastern Retina Associates

Appointment Date: ____

Appointment Time: ____

Appointment Location:

_____Weisgarber   _____UT Office   _____Baptist

_____Maryville   _____Morristown   _____Oak Ridge

_____St. Mary's   _____Crossville   _____Tennessee Valley Eye Center

SOUTHEASTERN RETINA ASSOCIATES, P.C.
MEDICATION LIST

NAME:	DOB:	DATE:
ALLERGIES:		

MEDICATION	STRENGTH	FREQUENCY	ADD	DC

Verified on:	By:	Verified on:	By:
Pt. states no change ☐	Changes as above ☐	Pt. states no change ☐	Changes as above ☐
Verified on:	By:	Verified on:	By:
Pt. states no change ☐	Changes as above ☐	Pt. states no change ☐	Changes as above ☐
Verified on:	By:	Verified on:	By:
Pt. states no change ☐	Changes as above ☐	Pt. states no change ☐	Changes as above ☐
Verified on:	By:	Verified on:	By:
Pt. states no change ☐	Changes as above ☐	Pt. states no change ☐	Changes as above ☐
Verified on:	By:	Verified on:	By:
Pt. states no change ☐	Changes as above ☐	Pt. states no change ☐	Changes as above ☐

Patient Demographic Information

Date: ________________________ SSN: ________-________-_________ Date of Birth: _________ - ________ - ________

Patient's Name: ___________________________________, ________________________, ______________, Age: _______
LAST FIRST MIDDLE

Address: ____ City_________________ State _______ Zip _________

Home Phone: ______ - ______ - ______ Work Phone: ______ - ______ - ______ Cell Phone: ______ - ______ - ______

Employer: __________________________ Occupation: ____________________ Marital Status: _______ Sex: ____________

Emergency Contact:________________________________ Phone: _______ - ________ - ________
Other than person living with you

Referring Doctor: ___________________________________ Phone: _______ - ________ - ________

Primary Care Doctor:_________________________________ Phone: _______ - ________ - ________

Spouse's Name:___________________________________ Spouse's SSN: _______ - _______ - ________

Spouse's Employer: _______________________________ Spouse's Work Phone: _______ - _______ - ________

Spouse's Date of Birth: ______-_____-_______ Spouse's Cell Phone: _______ - _______ - ________

Responsible Party if Patient is a Minor:

Last Name:_____________________ First Name: ______________ Relationship: _________ Date of Birth: _____ - _____ - _____

Address: ____ City_________________ State _______ Zip __________

Employer:____________________________________ Work Phone: _______ - _______ - ________ SSN: _____ - _____ - _____

Is your visit related to an accident? [ ] Yes [ ] No Will this be covered under Worker's Compensation? [ ] Yes [ ] No

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I authorize the disclosure of my personal health information to my referring physician, primary care physician, and insurance company, if applicable, via the use of written or fax transmittal, to carry out treatment, payment, or health care operations (TPO). I accept full financial responsibility for services rendered by Southeastern Retina Associates, P.C., and agree to pay all reasonable collection costs and attorney fees in the event of default of payment on my charges. I further authorize and request insurance payments be made directly to Southeastern Retina Associates, P.C. should they elect to receive such payment. My signature below indicates that I have read and fully understand the forth written authorization.

Signature: ____ Date: ________________________

MEDIGAP (SIGNATURE ON FILE STATEMENT FOR MEDICARE TO CROSSOVER 2ND INSURANCE)

Name of Beneficary____________________________________ HICN____

Medigap Policy Number__________________________________

I request that the payment of authorized Medigap benefits be made either to me or on my behalf to Southeastern Retina Associates, P.C. for any services furnished me by the provider. I authorize any holder of medical information about me to release to ______________________________any information needed to determine these benefits or the benefits payable for related services.
Name of Medigap Insurer

Beneficiary Signature____________________________________ Date____

My signature below indicates that a copy of The Privacy Policy for Southeastern Retina Associates has been made available to me.

Signature____ Date____

MEDICAL AND OCULAR

HISTORY QUESTIONNAIRE

SOUTHEASTERN RETINA ASSOCIATES, P.C.
Diseases and Surgery of the Retina and Vitreous

❑ John C. Hoskins, M.D. ❑ Joseph M. Googe, Jr., M.D.
❑ James H. Miller, Jr., M.D. ❑ Joseph M. Gunn, M.D.
❑ Tod A. McMillan, M.D. ❑ Howard L. Cummings, M.D
❑ D. Allan Couch, M.D. ❑ Stephen L. Perkins, M.D.
❑ Nicholas G. Anderson, M.D.

Account # ______________

Patient Name:____________________________ Sex:______ Age:______ Date:_____________

Eye Doctor:______________________________ Address:_______________________________

Medical Doctor:__________________________ Address:_______________________________

Please answer the following questions to the best of your ability. Give dates, a brief description, and which eye was involved to any **yes** question.

PRESENT ILLNESS

Please describe your current eye problem.____

____

____

OCULAR HISTORY

Have you ever had any eye disease, surgery, or injury in the past? ❑ No / ❑ Yes

If yes, please describe. Include dates and the name of the doctor who treated you.

Doctor Date Describe

____

____

Did any previous eye disorder result in loss of vision? ❑ No / ❑ Yes

If yes, please describe.____

Have you ever worn glasses or contact lenses? ❑ No / ❑ Yes

How old is your current prescription?____

Have you ever been told you have amblyopia or “lazy eye”? ❑ No / ❑ Yes

MEDICAL / SURGICAL HISTORY

Have you had any serious medical problems? ❑ No / ❑ Yes

(for example: heart, lung, kidney disease, high blood pressure, cancer or AIDS)

If yes, please describe. ____

Do you have diabetes? ❑ No / ❑ Yes

How long have you had diabetes?____

How often do you see your diabetes doctor?____

How often do you test your blood sugar?______________urine sugar?_________________

How high was your blood sugar when last tested?___________________________________

Have you ever had an insulin reaction? ❑ No / ❑ Yes

Date of last reaction:____

Patient Name:____Date:________________

Have you ever been hospitalized for any reason? ❑ No ❑ Yes
If yes, please describe. ____

Have you ever had any major surgery? ❑ No ❑ Yes
If yes, please describe. ____

Have you had any complications from anesthesia? ❑ No ❑ Yes

SOCIAL HISTORY

Educational level:
- High School ❑ No ❑ Yes
- College ❑ No ❑ Yes
- Post-Graduate ❑ No ❑ Yes
- Other:________________________________
- Present Occupation:______________________

Does your vision make it difficult for you to:
- Read? ❑ No ❑ Yes
- Write? ❑ No ❑ Yes
- Drive? ❑ No ❑ Yes
- Cook? ❑ No ❑ Yes
- Work? ❑ No ❑ Yes
- Watch TV? ❑ No ❑ Yes

Do you:
- Exercise less than 3 to 4 times a week? ❑ No ❑ Yes
- Avoid wearing seat belts? ❑ No ❑ Yes
- Use drugs? ❑ No ❑ Yes
- Drink alcohol? ❑ No ❑ Yes
- Smoke? ❑ No ❑ Yes
- Chew tobacco? ❑ No ❑ Yes
- Live alone? ❑ No ❑ Yes
- Have you ever had sexual contact with a person who may have been exposed to or infected with the AIDS virus? ❑ No ❑ Yes

FAMILY HISTORY

Is there any eye disease which runs in your family? ❑ No ❑ Yes
(for example: glaucoma, retinal detachment, or retinal degeneration)
If yes, please describe. ____

Has any member of your family lost vision for any reason? ❑ No ❑ Yes
If yes, please describe. ____

Is there any significant medical disease which runs in your family? ❑ No ❑ Yes
(for example: heart, lung, or kidney disease, high blood pressure or cancer)
If yes, please describe. ____

Patient Name:____Date:____________

REVIEW OF SYSTEMS

Have you ever had…

CARDIOVASCULAR:

Chest pain?	❑ No	❑ Yes
Enlarged heart?	❑ No	❑ Yes
Heart disease?	❑ No	❑ Yes
Heart murmur?	❑ No	❑ Yes
Irregular heart beat?	❑ No	❑ Yes
Shortness of breath?	❑ No	❑ Yes
Swelling of feet?	❑ No	❑ Yes
Phlebitis?	❑ No	❑ Yes
High blood pressure?	❑ No	❑ Yes

HEMATOLOGY:

Anemia?	❑ No	❑ Yes
Bleeding disease?	❑ No	❑ Yes
HIV+?	❑ No	❑ Yes
Venereal disease?	❑ No	❑ Yes
Sickle Cell disease?	❑ No	❑ Yes
Hepatitis?	❑ No	❑ Yes
Lyme disease?	❑ No	❑ Yes

NEUROLOGY:

Stroke?	❑ No	❑ Yes
Seizures?	❑ No	❑ Yes
Paralysis?	❑ No	❑ Yes
Dizziness?	❑ No	❑ Yes
Double vision?	❑ No	❑ Yes

GENITOURINARY:

Kidney trouble?	❑ No	❑ Yes
Urine problem?	❑ No	❑ Yes
Gonorrhea?	❑ No	❑ Yes
Syphilis?	❑ No	❑ Yes

PULMONARY:

Asthma/emphysema?	❑ No	❑ Yes
Cough?	❑ No	❑ Yes
Coughing blood?	❑ No	❑ Yes
Lung disease?	❑ No	❑ Yes
Pleurisy?	❑ No	❑ Yes
Pneumonia?	❑ No	❑ Yes
T.B.?	❑ No	❑ Yes
Wheezing?	❑ No	❑ Yes
Bronchitis?	❑ No	❑ Yes

ENDOCRINE:

Thyroid disease?	❑ No	❑ Yes
Diabetes?	❑ No	❑ Yes
Sarcoidosis?	❑ No	❑ Yes

PSYCHIATRY:

Depression?	❑ No	❑ Yes
Other disorders?	❑ No	❑ Yes

GASTROENTEROLOGY:

Stomach trouble?	❑ No	❑ Yes
Trouble with intestines?	❑ No	❑ Yes
Trouble with bowel movements?	❑ No	❑ Yes

REPRODUCTIVE:

Are you pregnant?	❑ No	❑ Yes

Date of last menstral period:________________

RHEUMATOLOGY:

Trouble with your joints?	❑ No	❑ Yes
Back trouble?	❑ No	❑ Yes

Other? ❑ No ❑ Yes

Describe.____

____

____

____

Patient Name:____Date:_____________

Do you have any allergies? ❑ No ❑ Yes

If Yes, Please Describe. ____

____

What kind of reactions have you experienced?_______________________________________

____

MEDICATIONS

Please list any medication(s) including **eye drops**, which you are taking. List the amount or strength of the medication(s) and how frequently you take the medication(s).

Name of Medication	Amount Taken	Times Taken	Eye

THIS SPACE RESERVED FOR PHYSICIAN ONLY

Chief Complaint/History of Present Illness: SYMPTOMS • LOCATION • QUALITY • SEVERITY • DURATION • TIMING • CONTEXT • MODIFIERS____

____

____

____

____

____

____

____

Physician's Signature:___________________________Tech. Init.__________Date:__________

Physical Exam for Hospital Admission

Vital Signs: Pulse_______ B/P_______ Resp._______Temp._______Mental Status_______

Head & Neck ❑ Normal ❑ Other____________ Extremities ❑ Normal ❑ Other____________

Abdomen ❑ Normal ❑ Other____________ Lungs ❑ Normal ❑ Other____________

Cardiovascular ❑ Normal ❑ Other____________ Neurologic ❑ Normal ❑ Other____________

Eyes ***See Admission Note***

Physician's Signature:_______________________________________Date:____________

NOTICE OF PRIVACY POLICIES
For
Southeastern Retina Associates, P.C. (SERA)

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Introduction

At SERA we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose this information. It also describes your rights as they relate to your protected health information. This Notice is effective October 1, 2002 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit SERA a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal documents describing the care you received,
- Means by which you or a third party payer can verify that services billed where actually provided,
- A tool in educating health professionals,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for medical research,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how you health information is used helps you to ensure accuracy, better understanding who, what, when, where, and why others may access your health information, and make more informed decision when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of SERA, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Southeastern Retina Associates, P.C. is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation or the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem
If you have questions and would like additional information, you may contact the practice's Privacy Officer, Sandra H. Brock at 865-588-0811.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. We will also provide your physician or subsequent health care provider with copies of various reports that should assist him or her in treating you once you're released back to your primary eye care physician.

We will use your health information for payment

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations

For example: Members of our organization may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

Other forms of Disclosure

Business Associates:
There are some services provided in our organization that utilize outside agencies. These include laboratories, and other forms of business associates that provide us a service. To protect your health information we require each of our business associates to sign a contract with our organization stating they will safeguard your information.

Notification:
We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition

Communication with Family:
We may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research:
We may disclose information to researchers when an institutional review board has approved their research, that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing:
We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Federal and State Agencies:
As required by law we may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

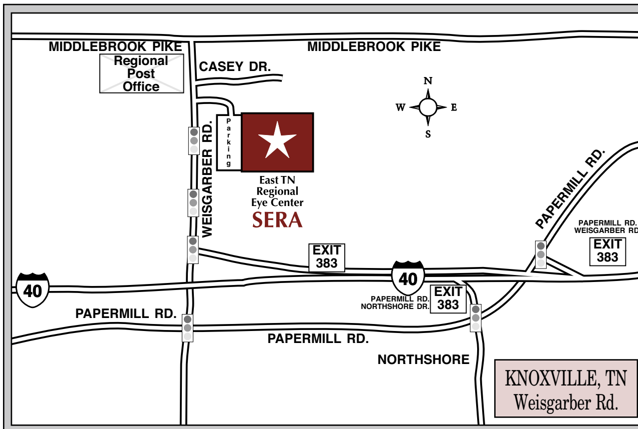
Law Enforcement:
We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Southeastern Retina Associates
Diseases and Surgery of the Retina and Vitreous

Knoxville Area Offices

John C. Hoskins, M.D.	Howard L. Cummings, M.D.
Randall L. Funderburk, M.D.	D. Allan Couch, M.D.
Joseph M. Googe, Jr., M.D.	Stephen L. Perkins, M.D.
James H. Miller, Jr., M.D.	Richard I. Breazeale, M.D.
Joseph M. Gunn, M.D.	Nicholas G. Anderson, M.D.
Tod A. McMillan, M.D.	Cris Larzo, M.D.



East TN Regional Eye Center

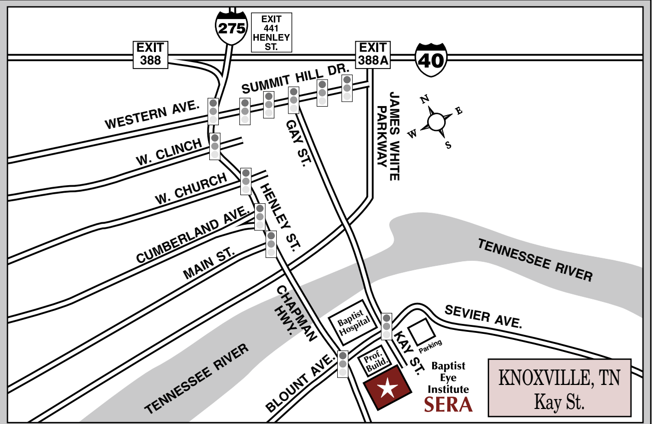
1124 E. Weisgarber Rd.,
Suite 207
Knoxville, TN 37909

PHONE
(865) 588-0811
FAX
(865) 584-2153

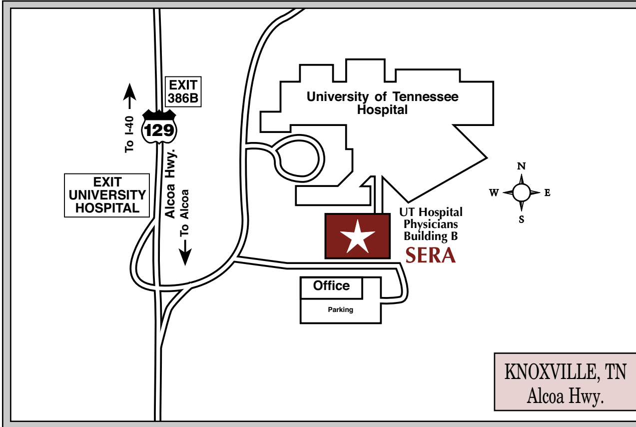
Baptist Eye Institute

2020 Kay Street
Knoxville, TN 37920

PHONE
(865) 579-3999
FAX
(865) 579-3987



Knoxville Area Offices
(continued)



UT Hospital Physicians Building B

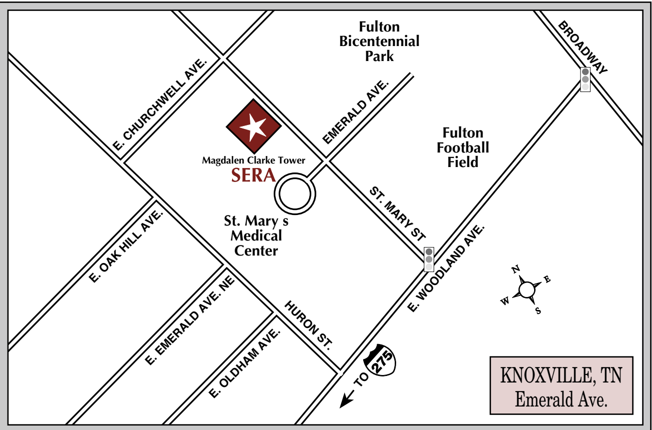
1928 Alcoa Hwy.,
Physicians Building B,
Suite 320
Knoxville, TN 37920

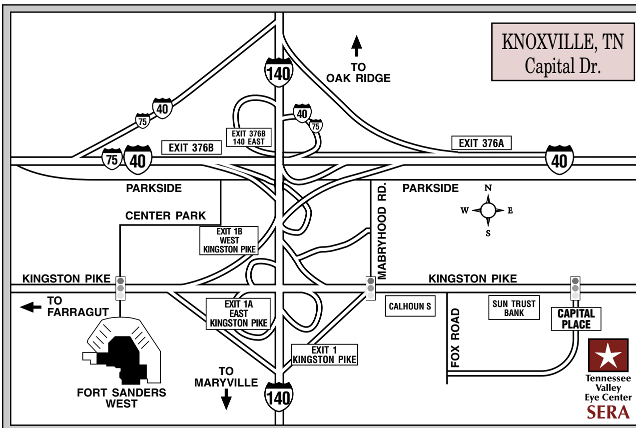
PHONE
(865) 522-5453
FAX
(865) 305-6696

Magdalen Clarke Tower

939 Emerald Ave.,
Suite 905
Knoxville, TN 37917

PHONE
(865) 546-7701
FAX
(865) 637-7198





Tennessee Valley Eye Center

140 Capital Dr.
Knoxville, TN 37922

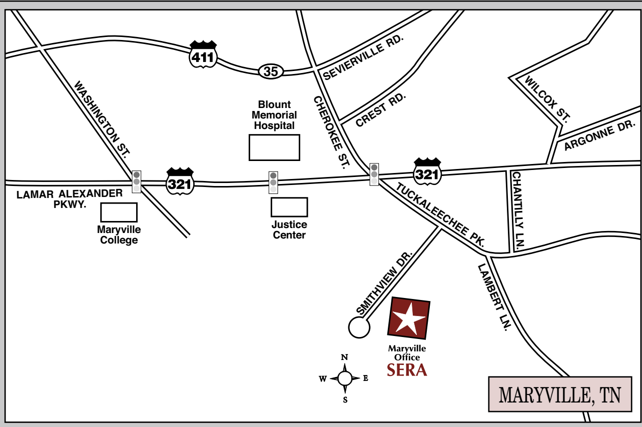
PHONE
(865) 251-0727
FAX
(865) 251-0728

Knoxville Area Offices
(continued)

Maryville

628 Smithview Drive
Maryville, TN 37803

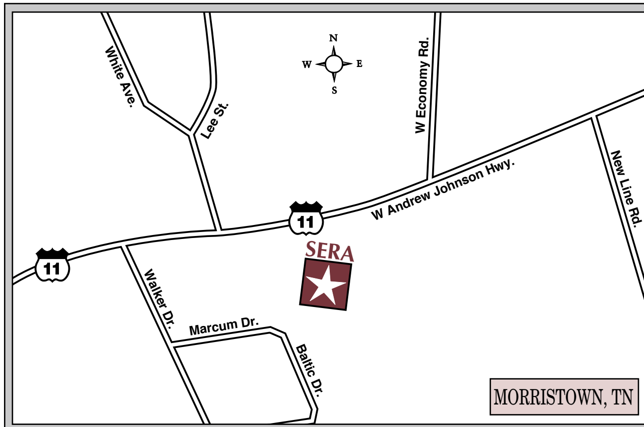
PHONE
(865) 977-4528
FAX
(865) 984-0981



Morristown

3101 W. Andrew Johnson Hwy.
Morristown, TN 37814

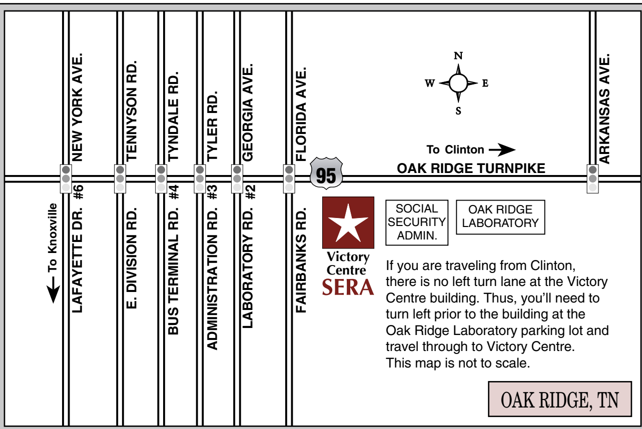
PHONE
(423) 581-1271
FAX
(423) 581-1510

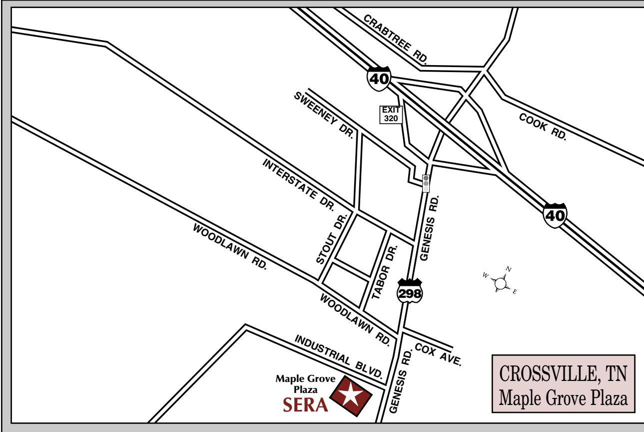


Oak Ridge

Victory Centre
575 Oak Ridge Trnpk., Suite 202
Oak Ridge, TN 37830

PHONE
(865) 482-3127
FAX
(865) 272-3259





Crossville
Maple Grove Plaza
1051 Genesis Rd.,
Suite 103
Crossville, TN 38555

PHONE
(931) 337-0522
FAX
(931) 337-0523

Appointment Information

INITIALS

Date ____________________

Day ____________________

Time ____________________

Doctor ____________________

Location ____________________

Patient's Name ____________________

24 hours notice is required if you are unable to keep your appointment time.
If unable to keep this appointment please telephone the office.

WORLD WIDE WEB ADDRESS
http://www.tennesseeretina.com

Abingdon, VA • Boone, NC • Bristol • Chattanooga • Cleveland • Crossville
Dalton, GA • Fort Payne, AL • Johnson City • Kingsport • Knoxville
Maryville • Morristown • Oak Ridge • Wytheville, VA

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