Vision For The Future

Kelly Vision Center

110 Glancy Street Suite 208
Goodlettsville, TN 37072
Tel. # (615)-868-2877 Fax # (615)-870-5771

Medical History

First Name: _____ Last Name: _____
Today's Date: _____/_____/_____ Birth Date: _____/_____/_____
Last Eye Exam (date): ____/_____/_____ Last Medical Exam (date): ____/_____/_____
Last Eye Doctor (name): _____ Last Medical Doctor (name): _____

What is your preferred Pharmacy? _____ Address of your Pharmacy? _____

What is your eye problem/complaint today? *Please describe this problem you are having as best as you can*

_____

Medications? *List all medications that you currently take (including Over-The-Counter, Vitamins, Supplements, Oral Contraceptives, etc) Do not worry about filling out a list of your medications if you already have a medication list that we can copy. Thank you*

_____

_____

Are you Allergic to any Medications? If so, please list_____

Personal Social History			*Circle all that apply*
Do you wear Glasses?	☐ Yes	☐ No	If Yes, How many Pairs? _____
Do you wear Contact Lenses?	☐ Yes	☐ No	If Yes, What Brand/Type? _____
Do you drive?	☐ Yes	☐ No	
Are you Nursing or Pregnant	☐ Yes	☐ No	
Do you use tobacco products? [*dip, e-cigs, cigarettes*]	☐ Yes	☐ No	If YES, do you use every day? ☐ Yes ☐ No If NO, have you used in the past? ☐ Yes ☐ No
Do you use recreational drugs?	☐ Yes	☐ No	If Yes, What type? _____
Do you drink alcohol?	☐ Yes	☐ No	If Yes, How often? _____
Have you ever had a Blood Transfusion?	☐ Yes	☐ No	
Have you ever had a STD?	☐ Yes	☐ No	

Birth Order? ☐ First ☐ Second ☐ Third ☐ Fourth ☐ Fifth ☐ >Fifth ☐ Only Child ☐ Identical Twin ☐ Fraternal Twin

Do you want Contact Lenses or Glasses RX at Todays Appointment? ☐ Contact Lenses RX Only ☐ Glasses RX Only ☐ BOTH ☐ Neither ☐ I Don't Know

How often are you on a Computer/TV/Phone a Day? ☐ 1-2 Hrs. ☐ 2-4 Hrs ☐ 4-6 Hrs ☐ 6-8 Hrs ☐ >8 Hrs

Current Weight: _____ **lb.** Current Height: _____**ft.** _____**inches**

Family Ocular/Medical History *Check Mark and Fill In all that Apply*	**Yes**	**No**	**Relationship To You?** *(Brother, Sister, Mother, Father, Paternal/Maternal Grandmother, Paternal/ Maternal Grandfather, etc.)* List all that Apply.
Blindness			
Glaucoma			
Cataracts			
Retinal Disease			
Macular Degeneration			
Arthritis			
Cancer			
Diabetes			
High Blood Pressure/Hypertension			
Other Disease(s)/ Prematurity			

Patient Review of Medical Systems *Check Mark Yes or No for Past or Present*		**Yes**	**No**
Allergies	Seasonal Allergies		
	Food		
	Other		
Cardiovascular	High Blood Pressure		
	High Cholesterol		
	Heart Attack		
	Stroke		
Constitutional	Anemia		
	Fever		
	Weight Changes		
	Dizziness		
	Motion Sickness		
	Sleep Problems		
Endocrine	Diabetes		
	Thyroid Disease		
	Gout		
	Pituitary Complication (s)		
Gastrointestinal	Diarrhea		
	Pancreatitis		
	Hepatitis		
Genitourinary	Genital Complication (s)		
	Kidney Complication (s)		
	Bladder Complication (s)		
	STD		
Ear, Nose, Throat, Mouth	Dental Complication (s)		
	Dryness		
	Sinus Complication (s)		
	Hearing Loss		
Hematologic/ Lymphatic	Sickle Cell Anemia		
	Blood Disorder		
	Breast Cancer		
Immunologic	Influenza (Flu)		
	Herpes		
	HIV		
	Lyme		
	Sarcoidosis		
	Cancer		
	Tuberculosis		
Integumentary	Skin Disease/Disorder		
	Lupus		
Musculoskeletal	Arthritis		
	Joint / Muscle Pain		
Neurological	Headaches/ Migraines		
	Seizures		
	Dyslexia		
	Parkinson		
	Multiple Sclerosis		

Patient Ocular History *Check Mark Yes or No for Past or Present*	**Yes**	**No**
Blindness or Loss of Vision		
Glaucoma		
Cataracts		
Retinal Disease		
Macular Degeneration		
Eye Injury		
Eye Infection		
Strabismus (Eye Turn In/Out)		
Amblyopia (Lazy Eye)		
Dry Eye		
Other Ocular Disease(s)		

Other Medical History/ Surgeries?

Please List all other Medical information that we need to know about.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____

Date: ___/____/_____

**By signing this form, I consent to treatment for myself and/or on behalf of the minor for which this information pertains. I give permission for the doctor to examine, diagnose, and initiate treatment as deemed appropriate*

Kelly Vision Center

PATIENT REGISTRATION

Name _____ **Date of Birth** _____
Last Name **First Name** **Middle Initial** **(MM/DD/YYYY)**

SEX: ☐ Male ☐ Female ☐ Other

Address _____

City _____ **State** _____ **Zip Code** _____ **Social Security #**_____

Home Phone (____)_____ **Cell Phone (____)**_____ **Is Texting OK?** ☐ Yes or ☐ NO

Email Address: _____ **Primary Care Physician**_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse Name_____ **Spouse Cell Phone (____)**_____

Preferred Language _____ **Ethnicity** _____ **Referred By**_____

Occupation _____ ☐ Full-Time ☐ Part-Time **Employer** _____

***STUDENTS*: School** _____ **Grade**_____

- *IF YOU ARE NOT THE INSURANCE POLICY HOLDER, PLEASE LIST THE POLICY HOLDER INFORMATION BELOW:*

Relationship to Insured: _____

Name: _____ **Date of Birth** _____
Last Name **First Name** **Middle Initial** **(MM/DD/YYYY)**

Address _____ **Sex:** ☐ **Male** ☐ **Female** ☐ **Other**

City _____ **State** _____ **Zip Code** _____ **Social Security #** _____

Cell Phone (____)_____

- I give permission for Dr. Kelly to discuss my visit with my guardian or spouse.

Patient or Guardian Signature:_____ **Date:** _____

- I give permission for Dr. Kelly to release records to my doctor(s) upon their request

Patient or Guardian Signature:_____ **Date:** _____

- I request that payment of authorized insurance benefits or any other third party payer be made to me or on my behalf to Dr. Marie C. Kelly and/or its independent contractor for any services furnished my by the provider. I authorize any holder of medical information about me to release to the agents or any third party payers any information needed to determine these benefits or the benefits payable for related services.

Patient or Guardian Signature:_____ **Date:** _____

KELLY VISION CENTER

Dr. Marie C. Kelly /Dr. J. Daniel Kelly

INSURANCE AUTHORIZATION AND BINDING FINANCIAL AGREEMENT

Providing the best possible eye care involves a mutual understanding between patient and provider. Please review the following policies, initial in the space provided, and let us know if we can answer any questions.

_____I authorize Dr. Marie C. Kelly to release information regarding my care to my insurance company in order to expedite claims or for records transfer should such events be required.

_____I authorize Dr. Marie C. Kelly to bill my insurance company for services provided to me, with payment made directly to the providing doctor's office and that such authorization is valid until written notice is provided to cancel that authorization.

_____I understand that Dr. Marie C. Kelly participates with vision plans (ex. VSP, EyeMed, etc.) for routine wellness exams, as well as medical insurances for eye health issues. The appropriate plan will be billed for any given service. Unfortunately, Dr. Marie C. Kelly is unable to participate with every HMO. I understand that if Dr. Kelly does not participate with my plan, I am free to pay out of pocket at the time of service and seek any out-of-network reimbursement directly from my insurer. This office will assist in this effort where possible.

_____While Dr. Marie C. Kelly makes every effort to verify my insurance coverage and benefits before services are provided, I understand that such information is NOT an official or legally binding decision of my out-of-pocket expenses. Verification of coverage is done as a courtesy only, and is not a guarantee of insurance coverage. Ultimately, my final costs are dependent on the final decision of my insurance carrier. I understand any copay estimate given to me prior to my examination may turn out to be different from the final decision of my insurance carrier. I agree that I am fully responsible to Dr. Kelly for payment of all charges, including any amount in excess of previous copay estimates.

_____I understand that if my insurance company fails to pay its anticipated balance in full, it is my responsibility to pay the doctor's bill. I will pay collection fees, attorney's fees, court cost, etc. for the purpose of collection on delinquent accounts.

_____In the event that I receive payment from my insurance company for services provided in this office, I agree to endorse any received payment to the doctor's office.

_____I understand there is a 30% restocking fee for all returned materials. There are no refunds after 30 days.

_____I understand that I must pay 50% of the total payment before my glasses can be ordered. I also understand that my glasses must be completely paid for before I can pick them up.

_____I understand there is a $45 fee for all returned checks.

Signature_____ Date_____

Print Name_____