



TENNESSEE LASIK

LASIK

PATIENT INFO PACKET

Privacy Practices



Patient Information



Medical History Questionnaire





TENNESSEE LASIK

Notice of Privacy Practices

1. THIS NOTICE DESCRIBES **HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED** AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY. This notice briefly summarizes how we handle your health information. Upon request, we will provide further details of our privacy policies and procedures.
2. **How we may use and disclose your health information.** We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. But beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop any future disclosures.
3. **Your rights.** In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe that your health information is incorrect or information is missing, you have the right request that we correct the existing information or add the missing information.
4. **Our legal duty.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgement of receipt of this notice. We may change our privacy policies any time. Before we make a significant change in our policies, we will change our notice. The notice will be prominently displayed at our location and on our website. You can also request a copy of our notice at any time. For more information about our privacy policies, contact our privacy officer.
5. **Privacy complaints.** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact our privacy officer. You may send a written complaint to the U.S. Department of Health and Human Services. Our privacy officer can provide you with the appropriate address upon request.

If you have any questions, please call Tennessee LASIK at (865) 966-9182.

Acknowledgement of receipt of Notice of Privacy Practices:

Sign, print your name and the date to acknowledge you have read and understand the Notice of Privacy Practices.

Signature: _____ Date: _____

Printed Name: _____

I give permission for the following people to have access to my Protected Health Information:

Family members: Name(s)/Relationship _____

Friend or Caregiver: Names(s)/Relationship _____

Signature _____ Date _____



TENNESSEE LASIK

Patient Information

Name _____ M F Date ____/____/____

Address _____ City: _____ State: ____ Zip: _____

Home: (____)____-____ Work: (____)____-____ Age: ____ DOB: ____/____/____

Social Security # _____ - _____ - _____ Email: _____

Emergency Contact: _____ Relationship to you: _____

Phone: (____)____-____

Are you: Nearsighted Farsighted Astigmatic Near w/Astigmatism Far w/Astigmatism

Do you primarily wear: Glasses or Contacts? Are your contacts Hard or Soft?

Has your prescription changed much in the past 3 years? Y N

Who is your regular Optometrist? _____ Phone #: (____)____-____

Have you been pregnant or nursed in the past three months? Y N

Do you have: Glaucoma Cataracts Retina Problems?

What sent you to us? (Check all that apply)

Radio Paper Internet Insurance Friend Optometrist

FOR OFFICE USE ONLY

Consultation Date: ____/____/____ @ ____:____ Procedure Date: ____/____/____ @ ____:____

1 Day Post Op: ____/____/____ @ ____:____ LASIK: OU OD OS

Option and Payments: PRK Custom FS200 Custom

\$ _____ CASH CHECK# _____ V MC D AMEX Care Credit

\$ _____ CASH CHECK# _____ V MC D AMEX Care Credit

\$ _____ CASH CHECK# _____ V MC D AMEX Care Credit

Discounts: _____

Insurance: _____



TENNESSEE LASIK

Medical History Questionnaire

Patient Name: _____ Today's Date: ____/____/____

Date of Birth: ____/____/____

SOCIAL HISTORY:

Occupation: _____ Marital Status: Single Married Divorced Widowed

Do you use tobacco products? Y N Do you use alcohol products? Y N

PERSONAL MEDICAL HISTORY:

Are you allergic to any medication? Y N If yes, please list:

List all medications that you are currently taking (prescription and over the counter):

Please list any eye injuries or eye surgeries you have had and their approximate dates:

DISEASE/CONDITION	Yes	No	Explain (if Yes)
Integument	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____

(continued)



Medical History Questionnaire

PERSONAL MEDICAL HISTORY: (continued)

DISEASE/CONDITION	Yes	No	Explain (if Yes)
Urinary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bone/Joint/Muscles	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lymphatic/Blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled

FAMILY MEDICAL HISTORY:

DISEASE/CONDITION	Yes	No	Relationship & Explanation (if Yes)
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Drops Every Day	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer (list what kind)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please list surgeries, hospitalizations, and serious illness you have had in the past 5 years:

Have you ever been told you have Glaucoma, Cataracts, or Retinal problems? Y N

Do you wear glasses? Y N If "yes" what are the age of your glasses? _____

Information reviewed by W. Colby Stewart, M.D. on ____/____/____

Doctor's Signature