Ronald E. McFarland M.D.

2021 Church Street, Suite 606
Nashville, TN 37203

PATIENT REGISTRATION AND HISTORY

Date: _____ Primary Care Doctor: _____

Name: _____ _____ _____ Sr. __ Jr. __

Address: _____ _____ _____ _____
Street City State Zip Code

Telephone: _____ _____ _____
Home Work Cell

Date of birth: _____ Social Security #: _____

Marital Status: ____ Single _____ Married ____ Other ____ None

Work Status: _____ Employed ____ None ____ Student

Gender: ____ M _____ F

Whom do we contact in case of emergency: _____
Additional contact other than emergency #: _____

Medical Insurance Information

1 – Primary Insurance: _____ Member ID #: _____
Co-pay Amount: _____ Deductible Amount: _____ Group#: _____

Who is responsible for primary insurance if not yourself? ___ Spouse ____ Parent
Name: _____ DOB: _____ Gender: ___ M ___ F

2 – Secondary Insurance: _____ Member ID #: _____
Co-pay Amount: _____ Deductible Amount: _____ Group#: _____

Who is responsible for primary insurance if not yourself? ___ Spouse ____ Parent
Name: _____ DOB: _____ Gender: ___ M ___ F

AUTHORIZATIONS

INSURANCRE AUTHORIZATION Primary or Secondary

I, the undersigned, have insurance coverage with _____

Name of Insurance Company

and assign directly to Dr. Ronald E. McFarland all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that if my insurance plan requires a referral / authorization to be seen for each visit, it is my responsibility to obtain all referrals needed before my visit. I also understand that if a referral is not received for any of my office visits I will be held financially responsible for the office charges. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured / Guardian *Date*

MEDICARE AUTHORIZATION Primary or Secondary

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Ronald E. McFarland for any services furnished me by Dr. McFarland. I authorize any holder of Medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment to be made and authorizes release of medical information necessary 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 physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signed _____ _____

Beneficiary Signature *Date*

Privacy practices Acknowledgement

Acknowledgement Form

I am aware that by signing below I may receive a copy of the office privacy practice form, at any time.

Name _____ DOB _____

Signature_____ DATE _____

Name: _____ *Today's Date:* _____

Date of Birth: _____ *Last Eye Exam:* _____

*Primary Care Doctor*_____ *Phone Number (____)*_____

*Whom may we thank for referring you to this office?*_____

*Relationship*_____

Medical History

Do you have any allergies to medications? No ❑ Yes ❑ If yes, please explain: _____

_____

Do you have any allergies to: shellfish, iodine, or contrast dye? No ❑ Yes ❑ If yes, please explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications, eye drops, and home remedies). Also include the name of the drug, dosage, and frequency: _____

_____

_____

_____

Have you had any of the following tests recently? Please check any/all you have had:

MRI ❑ CAT ❑ Scan ❑ Blood Tests ❑ Lumbar puncture (spinal tap) ❑

If yes please explain: _____

_____

List all major illness, injuries, surgeries, and/or Hospitalizations you have had and date, if possible:

_____

_____

Are you pregnant or nursing? No ❑ Yes ❑

Do you wear glasses? No ❑ Yes ❑ If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? No ❑ Yes ❑ If yes, how old is your present pair of lenses? _____

Have you ever been exposed or infected with the following (please check):

Gonorrhea ❑ Syphilis ❑ HIV ❑ Hepatitis ❑

Social History (If applicable)

Occupation:

Currently employed? No ❑ Yes ❑ Retired? No ❑ Yes ❑ Disabled? No ❑ Yes ❑

*If yes, type of disability*_____

Do you drive? No ❑ Yes ❑ If yes, do you have visual difficulty when driving? No ❑ Yes ❑

*If yes, please describe*_____

_____

Do you drink alcohol? No ❑ Yes ❑ If yes, type/how long: _____

Do you use tobacco products? No ❑ Yes ❑ If yes, type/amount, how long: _____

Do you use any illegal drugs? No ❑ Yes ❑ If yes, type/amount, how long: _____

Office of Dr. Ronald McFarland – REVIEW OF SYSTEMS

Today's Date_____

Name:_____ Date of Birth:_____

Do you currently (or have you ever had) any problems in the following areas? Also note any family history (parents, grandparents, siblings, and/or children, living or deceased) for the following medical conditions:

SYSTEMS	***Self***			***Family***	
EYES	***Yes***	***No***		***Yes***	***No***
Blindness					
Blurred Vision					
Burning/Tired Eyes					
Cataract					
Chronic Infection					
of Eye or Lid					
Crossed Eyes					
Distorted Vision/Halos					
Double Vision					
Drooping Eye Lid					
Dryness/Gritty Feeling					
Eye Pain or Soreness					
Flashes/Floaters in Vision					
Foreign Body Sensation					
Glare/Light Sensitivity					
Glaucoma					
Itching					
Loss of Vision					
Macular Degeneration					
Mucus Discharge					
Redness					
Retinal Detachment Disease					
Styles or Chalazion					
Serious Eye Injuries					
Eye Surgeries (list type)					
Eye Lasers (list type)					
Other					

SYSTEMS	***Self***			***Family***	
EARS, NOSE, THROAT	***Yes***	***No***		***Yes***	***No***
Allergies					
Chronic Cough					
Dry Throat/Mouth					
Hay Fever					
Hearing Loss/Ear Pain					
Post-Nasal Drip					
Runny Nose					
Sinus Congestion					

SYSTEMS	***Self***			***Family***	
ENDOCRINE (Thyroid/Other Glands	***Yes***	***No***		***Yes***	***No***
Diabetes					
Hormonal Disease					
Lupus					
Thyroid Disease					
Other					

SYSTEMS	***Self***			***Family***	
RESPIRATORY	***Yes***	***No***		***Yes***	***No***
Asthma/Bronchitis					
Breathing Difficulty					
Emphysema					
C.O.P.D.					
Infections					
Lung Disease					
Sarcoidosis					
Other					

SYSTEMS	***Self***			***Family***	
VASCULAR	***Yes***	***No***		***Yes***	***No***
Heart Attack					
Heart Failure					
Heart of Chest Pain					
High Blood Pressure					
Irregular Heart Rhythm					
Pacemaker					
Vascular Disease					
Heart					
Surgery/Type					
Other					

SYSTEMS	***Self***			***Family***	
CANCER	***Yes***	***No***		***Yes***	***No***
Chemotherapy of Any Kind					
Radiation Therapy					
Other					

List any Information that may be important to us and is not listed above_____

_____

*Today's Date*_____

*Name:*_____ *Date of Birth:*_____

REVIEW OF SYSTEMS (cont'd)

SYSTEMS	*Self*			*Family*	
GASTROINTESTINAL	*Yes*	*No*		*Yes*	*No*
Constipation					
Bloody Stools					
Diarrhea					
Hepatitis					
Loss of Bowel Control					
Ulcer Disease					
Other					

SYSTEMS	*Self*			*Family*	
GENITOURINARY (Genital/Kidney/Bladder)	*Yes*	*No*		*Yes*	*No*
Frequent Urination					
Kidney Stones					
Bladder Insufficiencies					
Urinary Bleeding					
Urinary Tract Infection					
Other					

SYSTEMS	*Self*			*Family*	
INTEGUMENTARY (Skin)	*Yes*	*No*		*Yes*	*No*
Rash					
Skin Tumors					
Other					

SYSTEMS	*Self*			*Family*	
LYMPHATIC/ HEMATOLOGIC	*Yes*	*No*		*Yes*	*No*
Anemia					
Sickly Cell Disease					
Bleeding Problems					
Bruise Easily					
Blood Loss/Transfusion					
Swollen Glands					
Other					

SYSTEMS	*Self*			*Family*	
MUSCULO-SKELETAL	*Yes*	*No*		*Yes*	*No*
Fractured Bones					
Muscle/Joint Pain					
Pain with Chewing					
Rheumatoid Arthritis					
Scalp Pain/Tenderness					
Gout					
Other					

SYSTEMS	*Self*			*Family*	
NEUROLOGIC	*Yes*	*No*		*Yes*	*No*
Headache					
Migraines					
Seizures					
Speech Difficulty					
Stroke					
Swallowing Difficulty					
Weakness, Numbness or Tingling					
Other					

SYSTEMS	*Self*			*Family*	
PSYCHIATRIC	*Yes*	*No*		*Yes*	*No*
Admission to Hospital for Psychiatric Illness					
Anxiety					
Depression					
Mood Swings					
Other					

Please list any surgeries _____

_____

_____

Please list any information or questions that may be important to assist us with your visit today

_____

_____

_____

We would like to thank you for your decision to become a patient of Dr. Ronald McFarland.
We look forward to providing you with the best care possible for many years to come.