

# Welcome to Our Office!

## Patient History

(\*all information is strictly confidential and ONLY used in your medical care\*)

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

SSN \_\_\_\_\_ Parent's SSN (if patient is a minor) \_\_\_\_\_

email \_\_\_\_\_ Date of last eye exam \_\_\_\_\_

Occupation \_\_\_\_\_ Hobbies \_\_\_\_\_

What pharmacy do you use? \_\_\_\_\_

Do you prefer to receive appointment information by mail, email, or text? \_\_\_\_\_

What brings you in today? \_\_\_\_\_

Referred by (if applicable): \_\_\_\_\_

Family Doctor / Primary Care Doctor: \_\_\_\_\_

Have you ever been treated for Diabetes or Hypertension? \_\_\_\_\_

Have you ever been treated for an autoimmune disease? \_\_\_\_\_

Have you ever had an eye injury, surgery, or disease? Y / N If yes, please explain  
\_\_\_\_\_

Do you take any medications? Please list and spell to the best of your ability.  
\_\_\_\_\_

Do you have any allergies to medications? \_\_\_\_\_

Do you have or have you ever experienced any of the following problems:

1. Chronic fever, fatigue, unexplained weight loss or gain? **Y/N**
2. Ear/nose/throat problems? **Y/N**
3. Heart problem? **Y/N**
4. Breathing problems? **Y/N**
5. Stomach/Intestinal problems? **Y/N**
6. Urinary Problems? **Y/N**
7. Skin Problems? **Y/N**
8. Muscle or Bone Problems? **Y/N**
9. Neurologic problems (numbness, weakness, headaches, paralysis)? **Y/N**
10. Psychiatric Problems? **Y/N**

Family and Social History:

1. Do you have any eye diseases in your family? (Macular Degeneration, Glaucoma)
2. Do you smoke? **Y/N**

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## NOTICE OF PRIVACY PRACTICES

Dr. Nathan Emmert, OD  
920 W G St, Elizabethton, TN  
423-543-2020

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the care we provide and may receive such records from others. We use these records to provide or to enable other health care providers to provide quality medical care; to obtain payment for services provided to you as allowed by your health plan; and to enable us to meet our professional and legal obligations to operate this medical practice. We are required by law to maintain the privacy of protected health information; to provide individuals with notice of our legal duties and privacy practices with respect to protected health information; and to notify affected individuals in case of a security breach. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this notice, please call our office.

### NO-SHOW POLICY

Three (3) no-shows will result in dismissal from our practice. If you are unable to keep your appointment, please notify the office at least 24 hours in advance so that the appointment may be offered to another patient. It is your responsibility to inform us immediately of any changes to your phone or address.

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Personal Representative (Printed)

\_\_\_\_\_  
Personal Representative Signature