East Tennessee Eye Surgeons
Dawson & Gallaher
Advanced Medicine & Surgery of the Eye

John T. Dawson, MD
Kevin T. Gallaher, MD

Please complete all sections of this form to the best of your ability

Name _____ **Date of Birth**_____

Address _____ **SSN** _____

City _____ **St** _____ **Zip** _____

Sex *(circle one)* **M F** **Marital Status** *(circle one)* **S M D W**

Home ☐ _____ **Work** ☐ _____ **Cell** ☐ _____

Please check the box(es) at the numbers above permitting us to contact you for appointment reminders or any other correspondence.

How did you hear about us? *(circle one)* Family/Friend Website Facebook Advertisement

Email address _____ **Employer** _____

Race_____ **Ethnicity** *(circle one)* ***Hispanic/Latino*** ***Not Hispanic/Latino***

We are required by law to request Race/Ethnicity information from you. If you prefer not to complete the Race and/or Ethnicity portion of the form, please write refused in the space above.

Emergency Contact _____ **Phone** _____

Preferred Pharmacy _____ **Location** _____

Referring Physician _____ **Primary Care Physician** _____

Friends/Relatives we may release your medical information to:

Name _____ **Relationship** _____

_____ _____

Insurance Information

Policy Holder Name *(example: Joe Smith)* _____

Relationship to patient _____ **Date of Birth** _____

- I authorize the release of any medical information necessary to process this claim. I also request payment of benefits to the provider on all claims that he may accept assignment on. I understand that I am responsible for all non-covered services and any balance that may not be covered by insurance. _____ ***(Initial)***
- I authorize the release of any information in my chart to any medical practitioner, insurance company, doctor, hospital, pharmacy, optical dispensary or any other medical institution to which I may be referred to assist with my medical care. _____ ***(Initial)***
- I understand that an annual refraction fee of $35.00 will not be covered by most health insurance policies and that I am responsible for payment of this fee plus my co-pay (if applicable) at the time of service. A refraction is a vision test that is a necessary part of a complete eye exam. _____ ***(Initial)***
- I acknowledge the Notice of Privacy Practices is kept on file in the practice and is available for my review and can be explained to me if I have any questions. _____ ***(Initial)***
- I authorize East TN Eye Surgeons to enroll me in the Patient Portal website so I can view my medical records and communicate with the office staff online. _____ ***(Initial)***

Sign _____ **Date** _____

Medication List

Name:_____ Date:_____

Drug Name	Dose (milligrams)	Schedule (how often)

Review of Systems

Name:_____ Date:_____

Tobacco Use: Yes / No Type _____ Age Quit_____

Alcohol Use: Yes / No Amount? _____

PLEASE CIRCLE "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH

Constitutional

Fatigue	Y	N
Fever	Y	N
Night sweats	Y	N
Weakness	Y	N
Unexplained weight gain	Y	N
Unexplained weight loss	Y	N

Ears/Nose/Throat

Hearing loss	Y	N
Sinus problems	Y	N

Respiratory

Asthma	Y	N
Cough	Y	N
Wheezing	Y	N

Cardiovascular

Chest pressure	Y	N
Irregular heartbeat	Y	N

Gastrointestinal

Constipation	Y	N
Diarrhea	Y	N
Nausea/vomiting	Y	N

Genitourinary

Difficult or painful urination	Y	N
Blood in Urine	Y	N

Metabolic/Endocrine

Cold intolerance	Y	N
Heat intolerance	Y	N
Excessive Thirst	Y	N
Increased Appetite	Y	N
Excessive Urination	Y	N

Neurological

Dizziness	Y	N
Headache	Y	N
Numbness	Y	N
Difficulty Walking	Y	N

Psychiatric

Depression	Y	N
Irritability Changes	Y	N

Integumentary

Rash	Y	N
Skin lesion/nodules	Y	N

Musculoskeletal

Arthritis	Y	N
Joint swelling	Y	N
Muscle weakness	Y	N

Hematologic/Lymphatic

Abnormal Bleeding	Y	N
Abnormal Bruising	Y	N

Immunologic

Environmental allergies	Y	N
Food allergies	Y	N