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)***

Sign _____ **Date** _____