Dr. Jason W. Wilkerson, O.D.
Dr. Jana P. Socey, O.D.
506 Willow Street Springfield, TN 37172
Phone: (615) 384-8435 | Fax: (615) 384-0855

Patient Information:		
Last Name:	First Name:	Middle Initial:
Date of Birth:	Age:	Social Security #:
Street Address:		
City:	State:	Zip code:
Cell Phone:	Home/Work Ph:	Email:
Sex: Male ☐ Female ☐	Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐	
Employer:	Occupation:	
Referral Method: Family/Friend ☐_____ Physician ☐_____ Internet ☐ Social Media ☐		
Primary Care Physician:	Pharmacy:	

Insurance Information:

Medical Insurance Name: _____ Member ID: _____
Guarantor Name: _____
2° Medical Insurance Name: _____ Member ID: _____
Guarantor Name: _____
Vision Insurance Name: _____ Member ID: _____
Guarantor Name: _____

Emergency Contact (Other than Guarantor):	
Name:	Phone:

Privacy Policy: Due to the Privacy Act effective April 14th, 2003, do we have your permission to perform the following regarding appointments, medical conditions, or billing inquiries:
Leave a voicemail ☐ Send email ☐ Send Text ☐ Speak w/ spouse, guardian, or family member ☐

Would you like a copy of our Notice of Privacy Practices for Protected Health Information as recommended by the HIPAA Privacy Rule? (This is a 6-page document describing how medical information about yourself may be used and disclosed and how you can get access to this information.) **YES** ☐ **NO** ☐

I request that payment of the authorized health insurance benefits be made on my behalf to Springfield Primary Eye Care, Inc for any services furnished to me. **I understand my insurance benefits, limitations, and exclusions, and I agree to pay any non-covered services, collection fees, and attorney fees necessary to collect the balance.** I also authorize any medical information about me to be released to my Insurer as needed to determine benefits.

Patient or Guarantor Signature:	**Date:**

Medical History:			If yes, please explain:
Eyes: Cataract, Glaucoma, Macular Degen., Retinal Detach	Y	N	
Constitutional: Weight loss/gain, Fever, Fatigue	Y	N	
Ear, Nose, Throat: Sinus, Hearing loss	Y	N	
Cardiovascular: Heart, Hypertension, Cholesterol	Y	N	
Respiratory: Asthma, COPD, Sleep apnea	Y	N	
Gastrointestinal: Constipation, Diarrhea, Liver	Y	N	
Genital or Urinary: STDs, UTIs, Prostate	Y	N	
Muscles, Bones, Joints: Arthritis	Y	N	
Skin: Eczema, Shingles, Psoriasis, Rosacea	Y	N	
Neuro: Seizures, Paralysis, Headaches	Y	N	
Psychiatric: Anxiety, Depression	Y	N	
Endocrine: Diabetes, Thyroid	Y	N	
Immunologic: Allergies, Lupus, Sarcoid	Y	N	
Blood/Lymph: Anemia, Transfusions	Y	N	
Cancer: Breast, Lung, Prostate, Colon	Y	N	

Medications:	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Surgeries/Injuries:	List Here:

Family History: please list mother, father, sibling, etc for each

Macular Degen. Glaucoma Diabetes HTN Heart Stroke Cancer Other: _____

Allergies:	
1.	2.

Social History:

Alcohol Use?	Y	N	How much/week? _____	Tobacco Use?	Y	N	How much/week? _____