



Southeastern Retina Associates, P.C.  
Diseases and Surgery of the Retina and Vitreous  
7268 Jarnigan Road, Suite 300, Chattanooga TN, 37421  
Phone: 423-756-1002

**PLEASE COMPLETE ALL THE ENCLOSED INFORMATION BEFORE ARRIVING FOR YOUR APPOINTMENT AND PRESENT IT TO THE RECEPTIONIST (please do not mail). YOU WILL BE DILATED AT EVERY VISIT THEREFORE IT IS ALWAYS RECOMMENDED THAT YOU BRING A DRIVER.**

Dear Patient:

We would like to welcome you to Southeastern Retina Associates. Please visit our website [www.tennesseeeretina.com](http://www.tennesseeeretina.com) for more information about our practice, physicians, and various locations in Tennessee and surrounding states.

Thorough retinal evaluation requires that you spend more time in our office than would be necessary for a general eye examination. Collection of medical information and a variety of tests must be performed both before and after dilation of the pupils. You therefore have TWO (2) appointment times: one *before dilation* and one *after dilation*. Adequate time must be available for both exams if we are to serve you well. If the first examination is not completed at the scheduled time there is no time left for the second exam.

Please remember that traffic and parking can add to delays at the Erlanger office and to allow for additional travel time at this location. If you discover that you are going to be late please call as soon as possible to see whether time will be available to proceed with the examination or whether it needs to be rescheduled.

Should you arrive late it may be necessary to reschedule your appointment so as not to compromise the quality of your care. We do understand that unforeseeable delays may occur. We will try to accommodate the occasional patient who is late, but this may not always be possible without depriving other patients of their own scheduled appointment times.

Thank You

APPOINTMENT DATE: \_\_\_\_\_

ARRIVAL TIME FOR WORK-UP AND DILATION: \_\_\_\_\_

**YOUR DOCTOR APPOINTMENT TIME WILL BE 30 MINUTES AFTER YOUR ARRIVAL TIME.**

\_\_\_ JARNIGAN MEDICAL CENTER

\_\_\_ ERLANGER MEDICAL CENTER

\_\_\_ CLEVELAND

\_\_\_ DALTON

\_\_\_ FORT PAYNE



Southeastern Retina Associates, P.C.  
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Randall L. Funderburk, M.D. • Richard I. Breazeale, M.D. • Brett D. Gerwin, M.D.

## HISTORY QUESTIONNAIRE

Date: \_\_\_\_\_ Account # \_\_\_\_\_

Patient Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Eye Doctor: \_\_\_\_\_ Address: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_ Address: \_\_\_\_\_

Please answer the following questions to the best of your ability. Give dates, a brief description, and which eye was involved to any "Yes" question.

### PRESENT ILLNESS

Please describe your current eye problem: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### OCULAR HISTORY

Have you ever had any eye disease, surgery, or injury in the past?  No /  Yes

If yes, please describe. Include dates and the name of the doctor who treated you.

Doctor: \_\_\_\_\_ Date: \_\_\_\_\_ Describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Did any previous eye disorder result in loss of vision?  No /  Yes

If yes, please describe: \_\_\_\_\_

Have you ever worn glasses or contact lenses?  No /  Yes

How old is your current prescription? \_\_\_\_\_

Have you ever been told you have amblyopia or "lazy eye"?  No /  Yes

### MEDICAL / SURGICAL HISTORY

Have you had any serious medical problems?  No /  Yes

(For example: heart, lung, kidney disease, high blood pressure, cancer or AIDS)

If yes, please describe: \_\_\_\_\_

Do you have Diabetes?  No /  Yes

How long have you had diabetes? \_\_\_\_\_

How often do you see your diabetes doctor? \_\_\_\_\_

How often do you test your blood sugar? \_\_\_\_\_

How high was your blood sugar when last tested? \_\_\_\_\_

Have you ever had an insulin reaction?  No /  Yes

Date of last reaction? \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Have you ever been hospitalized for any reason?  No /  Yes

If yes, please describe: \_\_\_\_\_

Have you ever had any major surgery?  No /  Yes

If yes, please describe: \_\_\_\_\_

Have you had any complications from anesthesia?  No /  Yes

**SOCIAL HISTORY**

Educational level: High School  No /  Yes

College  No /  Yes

Post-Graduate  No /  Yes

Other: \_\_\_\_\_

Present Occupation: \_\_\_\_\_

Does your vision make it difficult for you to: Read?  No /  Yes

Write?  No /  Yes

Drive?  No /  Yes

Cook?  No /  Yes

Work?  No /  Yes

Watch TV?  No /  Yes

Do you: Exercise less than 3 to 4 times a week?  No /  Yes

Avoid wearing seat belts?  No /  Yes

Use drugs?  No /  Yes

Drink alcohol?  No /  Yes

Smoke?  No /  Yes

Chew tobacco?  No /  Yes

Live alone?  No /  Yes

Have you ever had sexual contact with a person who may have been exposed to or infected with the AIDS virus?  No /  Yes

**FAMILY HISTORY**

Is there any eye disease which runs in your family?  No /  Yes

(for example: glaucoma, retinal detachment, or retinal degeneration)

If yes, please describe: \_\_\_\_\_

Has any member of your family lost vision for any reason?  No /  Yes

If yes, please describe: \_\_\_\_\_

Is there any significant medical disease which runs in your family?  No /  Yes

(for example: heart, lung, kidney disease, high blood pressure or cancer)

If yes, please describe: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**REVIEW OF SYSTEMS - Have you ever had...**

**CARDIOVASCULAR:**

- Chest pain?  No /  Yes
- Enlarged heart?  No /  Yes
- Heart disease?  No /  Yes
- Heart murmur?  No /  Yes
- Irregular heart beat?  No /  Yes
- Shortness of breath?  No /  Yes
- Swelling of feet?  No /  Yes
- Phlebitis?  No /  Yes
- High blood pressure?  No /  Yes

**HEMATOLOGY:**

- Anemia?  No /  Yes
- Bleeding disease?  No /  Yes
- HIV+?  No /  Yes
- Venereal disease?  No /  Yes
- Sickle Cell disease?  No /  Yes
- Hepatitis?  No /  Yes
- Lyme disease?  No /  Yes

**NEUROLOGY:**

- Stroke?  No /  Yes
- Seizures?  No /  Yes
- Paralysis?  No /  Yes
- Dizziness?  No /  Yes
- Double vision?  No /  Yes

**GENITOURINARY:**

- Kidney trouble?  No /  Yes
- Urine problem?  No /  Yes
- Gonorrhea?  No /  Yes
- Syphilis?  No /  Yes
  
- Other?  No /  Yes

**PULMONARY:**

- Asthma/emphysema?  No /  Yes
- Cough?  No /  Yes
- Coughing blood?  No /  Yes
- Lung disease?  No /  Yes
- Pleurisy?  No /  Yes
- Pneumonia?  No /  Yes
- T.B.?  No /  Yes
- Wheezing?  No /  Yes
- Bronchitis?  No /  Yes

**ENDOCRINE:**

- Thyroid disease?  No /  Yes
- Diabetes?  No /  Yes
- Sarcoidosis?  No /  Yes

**PSYCHIATRY:**

- Depression?  No /  Yes
- Other disorders?  No /  Yes

**GASTROENTEROLOGY:**

- Stomach trouble?  No /  Yes
- Trouble with intestines?  No /  Yes
- Trouble with bowel movements?  No /  Yes

**REPRODUCTIVE:**

- Are you pregnant?  No /  Yes
- Date of last menstrual period: \_\_\_\_\_

**RHEUMATOLOGY:**

- Trouble with your joints?  No /  Yes
- Back trouble?  No /  Yes

Describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



# Pharmacy Information

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_

## Prescription Insurance Information

Insurance Name: \_\_\_\_\_

Policyholder: \_\_\_\_\_

(Check one)  Member  Spouse  Minor

RX Group Number: \_\_\_\_\_

RX ID Number: \_\_\_\_\_

**\*\*\*\*Please bring your Prescription Card with you\*\*\*\***

**NOTICE OF PRIVACY POLICIES**  
**For**  
**Southeastern Retina Associates, P.C. (SERA)**

**THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**Introduction**

At SERA we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose this information. It also describes your rights as they relate to your protected health information. This Notice is effective October 1, 2002 and applies to all protected health information as defined by federal regulations.

**Understanding Your Health Record/Information**

Each time you visit SERA a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal documents describing the care you received,
- Means by which you or a third party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for medical research,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to ensure accuracy, better understanding who, what, when, where, and why others may access your health information, and make more informed decision when authorizing disclosure to others.

**Your Health Information Rights**

Although your health record is the physical property of SERA, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

**Our Responsibilities**

Southeastern Retina Associates, P.C. is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation or the authorization according to the procedures included in the authorization.

### **For More Information or to Report a Problem**

If you have questions and would like additional information, you may contact the practice's Privacy Officer, Sandra H. Brock at 865-588-0811.

### **Examples of Disclosures for Treatment, Payment and Health Operations**

*We will use your health information for treatment*

**For example:** Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. We will also provide your physician or subsequent health care provider with copies of various reports that should assist him or her in treating you once you're released back to your primary eye care physician.

*We will use your health information for payment*

**For example:** A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

*We will use your health information for regular health operations*

**For example:** Members of our organization may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

### **Other forms of Disclosure**

**Business Associates:**

There are some services provided in our organization that utilize outside agencies. These include laboratories, and other forms of business associates that provide us a service. To protect your health information we require each of our business associates to sign a contract with our organization stating they will safeguard your information.

**Notification:**

We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition

**Communication with Family:**

We may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

**Research:**

We may disclose information to researchers when an institutional review board has approved their research, that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

**Marketing:**

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Federal and State Agencies:**

As required by law we may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

**Law Enforcement:**

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.



**SOUTHEASTERN RETINA ASSOCIATES**  
Diseases and Surgery of the Retina and Vitreous

# Chattanooga Area Offices

WORLD WIDE WEB ADDRESS  
<http://www.tennessee retina.com>

John C. Hoskins, M.D.  
Randall L. Funderburk, M.D.  
Joseph M. Googe, Jr., M.D.  
James H. Miller, Jr., M.D.  
Joseph M. Gunn, M.D.  
Tod A. McMillan, M.D.

Howard L. Cummings, M.D.  
D. Allan Couch, M.D.  
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PHONE  
**(423) 756-1002**

FAX  
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## Jarnigan Medical Center

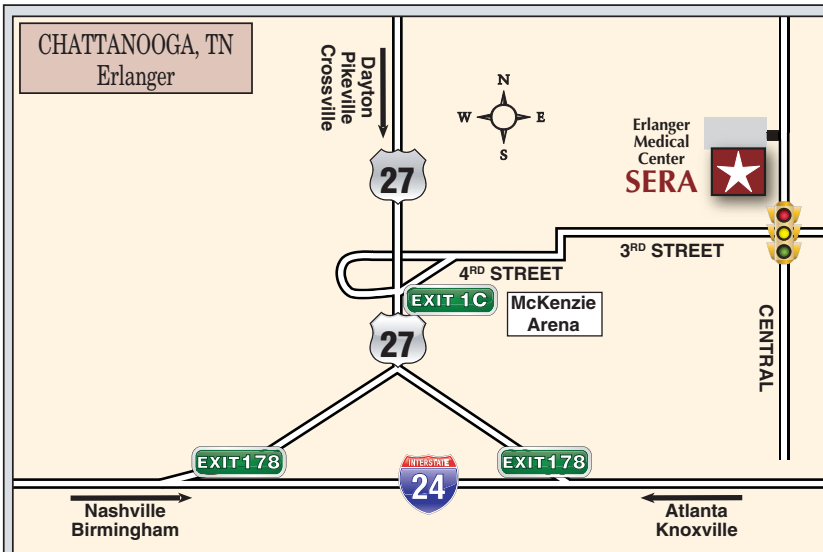
Suite 300  
7268 Jarnigan Rd.  
Chattanooga, TN 37421



CHATTANOOGA, TN  
Erlanger

## Erlanger Medical Center

979 E. Third St.,  
Suite C-235  
Chattanooga, TN 37403



Chattanooga Area Offices

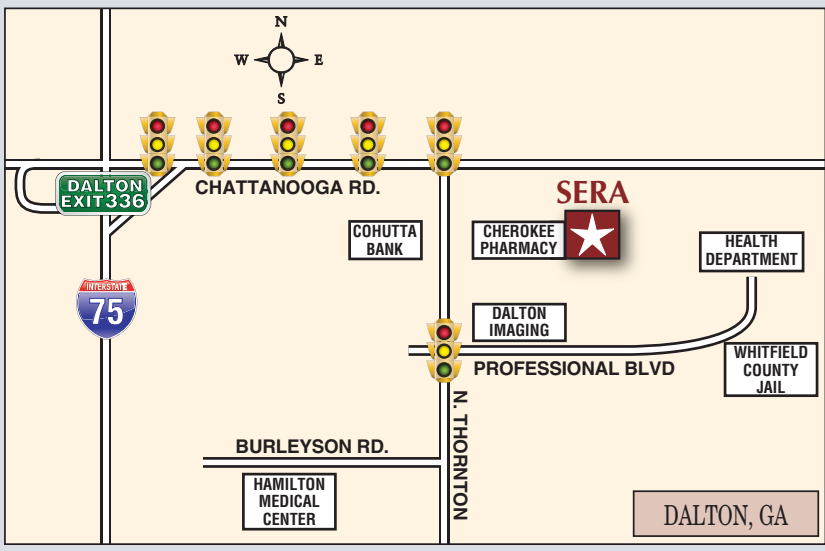
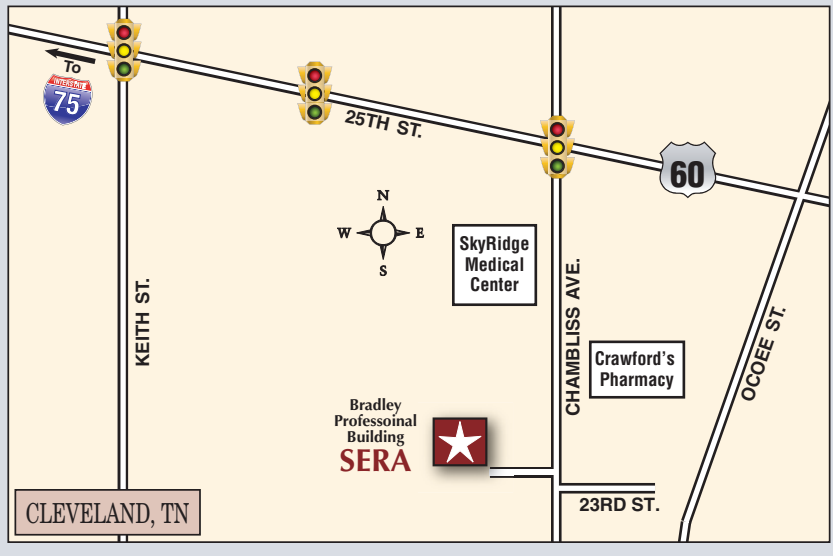
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PHONE  
**(423) 756-1002**

FAX  
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**Bradley Professional Building**

2253 Chambliss Ave.,  
Suite 410  
Cleveland, TN 37311



**Dalton**

1506 N. Thornton Ave.,  
Suite C  
Dalton, GA 30720

**Ft. Payne**

2202 Jordan Rd., SW  
Suite 500  
Ft. Payne, AL 35967

