

# WELCOME TO OUR PRACTICE!

*Drs. Seal & Hildebrand*

1042 E Third Street #102 • Chattanooga, Tennessee 37403

Phone: (423) 265-1651 • Fax: (423)756-0050

Date: \_\_\_\_\_ Chart #: \_\_\_\_\_ SSN: \_\_\_\_\_

Full Legal Name \_\_\_\_\_ Age: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail address \_\_\_\_\_

Home # (\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_ Work# (\_\_\_\_) \_\_\_\_\_

Sex: Male Female DOB: \_\_\_\_\_ Marital Status: M S D W

Spouse's Name \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Spouse's DOB: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Race: White Black Asian Native American Indian Other: \_\_\_\_\_ Not Stated

Ethnicity: Hispanic/Latino Other \_\_\_\_\_

Language: English Spanish Other \_\_\_\_\_

Employment Status: Employed Unemployed Disabled Retired Full / Part time Student

Employed by: \_\_\_\_\_

Emergency Contact Information: Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

Consent to allow access to protected health information: I consent for Drs. Seal & Hildebrand to contact me to disclose my protected health information to the emergency contact identified above. I may revoke consent at any time by giving written notice.

Signature of patient / Legal Guardian

Date

Authorization & Release: I authorize the release of any information concerning my/my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of surgical or medical benefits to Drs. Seal & Hildebrand. I understand I am responsible for charges not covered by insurance, including copays and refraction fee. Photocopy of this authorization is as valid as the original.

Signature of Patient / Legal Guardian

Date

*Please turn to reverse side and complete information if patient is under 18 years of age*

Please complete if patient is under 18 years of age

*Father/Legal Guardian:* \_\_\_\_\_ *DOB:* \_\_\_\_\_

*SSN:* \_\_\_\_\_ *Contact Phone# ( )* \_\_\_\_\_

*Address:* \_\_\_\_\_

*Employer:* \_\_\_\_\_ *Phone # ( )* \_\_\_\_\_

*Mother/Legal Guardian:* \_\_\_\_\_ *DOB:* \_\_\_\_\_

*SSN:* \_\_\_\_\_ *Contact Phone# ( )* \_\_\_\_\_

*Address:* \_\_\_\_\_

*Employer:* \_\_\_\_\_ *Phone # ( )* \_\_\_\_\_

Name \_\_\_\_\_

Date of birth \_\_\_\_\_

**FAMILY AND PERSONAL HISTORY**

Please note any family history for the following conditions:

Problem details/Surgeries

**Disease/Condition**                      **self**   **relative**   **none**

Blindness			
Cataract			
Crossed Eyes			
Glaucoma			
Macular Degeneration			
Retinal Detachment/Disease			
Diabetes			
Heart Disease			
High Blood Pressure (Hypertension)			
Cancer			
Kidney Disease			
Lupus			
Thyroid			
Arthritis			
Other			

Do you currently have any problems in the following areas? If YES please provide additional information

YES NO

EYES (poor vision, eye pain, tearing, redness, etc.)		
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)		
EARS, NOSE, THROAT (heard of hearing, stuffy nose, earache, cough, dry mouth, etc.)		
CARDIOVASCULAR (high BP, racing pulse, etc.)		
RESPIRATORY (congestion, wheezing, short of breath, etc.)		
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)		
FEMALE Are you pregnant? Nursing?		
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)		
SKIN (pimples, warts, growths, rash, etc.)		
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)		
PSYCHIATRIC (anxiety, depression, insomnia)		
ENDOCRINE (diabetes, hypothyroid, etc.)		
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)		
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)		

\_\_\_\_\_  
Primary Care Physician                      Phone

\_\_\_\_\_  
Pharmacy    Phone

**SOCIAL HISTORY**

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?    YES      NO

Do you drink alcohol?    YES    NO  
If yes, how much? \_\_\_\_\_

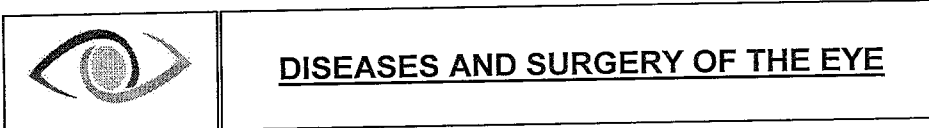
Do you smoke?    YES    NO  
If yes, how much \_\_\_\_\_

How many years \_\_\_\_\_

Reviewed and updated

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





PATIENT CONSENT FOR MEDICAL RECORDS

\_\_\_\_\_ TO: MOLLY R. SEAL, M.D.  
CALE HILDEBRAND, M.D.

\_\_\_\_\_ FROM: 1042 E THIRD STREET #102  
CHATTANOOGA, TN 37403  
PHONE (423) 265-1651  
FAX (423) 756-0050

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DOCTOR / FACILITY/ PATIENT INFORMATION:

\_\_\_\_\_ TO: NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

\_\_\_\_\_ FROM: \_\_\_\_\_  
PHONE: (\_\_\_\_\_) \_\_\_\_\_  
FAX: (\_\_\_\_\_) \_\_\_\_\_

I HEREBY AUTHORIZE RELEASE OF MY MEDICAL RECORDS AS REQUESTED:

\_\_\_\_\_ FULL RECORDS      \_\_\_\_\_ VERBAL CONSULTATION

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

DATE OF BIRTH: \_\_\_\_\_      SSN#: \_\_\_\_\_

PATIENT SIGNATURE/  
LEGAL GUARDIAN: \_\_\_\_\_

DATE SIGNED: \_\_\_\_\_

DATE REQUEST SENT: \_\_\_\_\_

The information in this request is confidential and privileged. If you receive this request in error, please contact our office at the above numbers. Thank you.