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:

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			

Problem details/Surgeries

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

_____ _____

_____ _____

DISEASES AND SURGERY OF THE EYE

Molly R. Seal, M.D.
Cale Hildebrand,M.D.

1042 E 3rd St. Suite 102
Chattanooga, TN 37403
Phone (423) 265-1651
Fax (423) 756-0050

PATIENT NAME: **DOB:**

MEDICATION LIST	DOSAGE	FREQUENCY	RT OF ADMIN

LIST ANY ALLERGIES	REVIEWED & UPDATED		

DISEASES AND SURGERY OF THE EYE

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.