Carl E. Flinn, M.D.
Pediatric Ophthalmology & Adult Strabismus
773 Estate Place
Memphis, TN 38120
(901) 681-4040

Dear Patient,

Dr. Carl Flinn's office wishes to welcome you to our growing number of new patients and to thank you for choosing our office to serve your family's eye needs.

In effort to help make your visit a pleasant experience, we have enclosed our patient information sheets for you to complete and bring on the day of your appointment, and verified your insurance benefits, if available. Please present us your medical insurance card, referral (if needed), and medical specialist co-pay when you sign-in. All visits are filed under medical insurance only. Should you not carry medical insurance or have not met your policy's deductible, payment-in-full will be collected at the end of the exam. For your convenience, we accept cash, checks, Visa, MasterCard, and Discover.

Occasionally, an emergency may occur, and you may need to reschedule your appointment. Please call a day in advance of your scheduled appointment to avoid a fee.

Once again, thank you for allowing us to serve you family's eye needs. Please call our office at (901) 681-4040 if you have any questions.

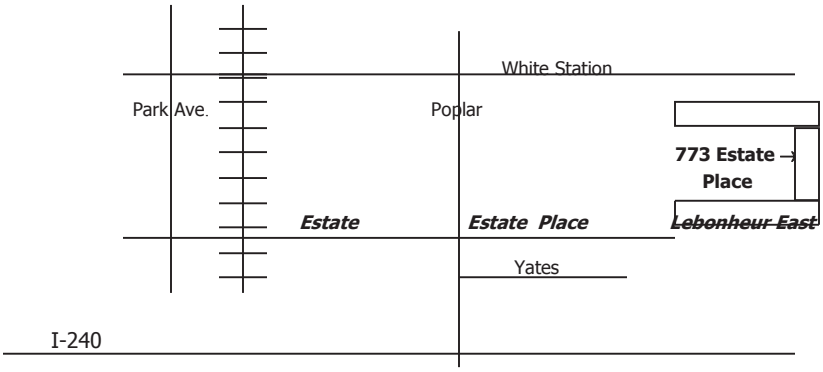
Sincerely,

The Office of Carl Flinn, M.D.

Area Map:

We are located at:

773 Estate Place in the LeBonheur East Complex



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PATIENT INFORMATION FORM

DATE: _____

PATIENT INFORMATION:

NAME: (FIRST, MIDDLE, LAST) _____

DOB: _____ SEX _____ SSN: _____ RACE: _____ ETHNICITY: _____

ADDRESS (STREET, CITY, STATE, ZIP): _____

HOME PHONE: _____ CELL: _____ EMAIL: _____

MARITAL STATUS: _____ PRIMARY LANGUAGE: _____ SPECIAL NEEDS: _____

IF PATIENT IS A MINOR WITH WHOM DOES HE/SHE LIVE? _____

OTHER FAMILY MEMBERS SEEN HERE? (PLEASE NAME) _____

EMERGENCY INFORMATION:

PATIENT'S PRIMARY DOCTOR _____ PHONE _____

REFERRING PHYSICIAN _____ PHONE _____

IN CASE OF EMERGENCY, WHO MAY WE CONTACT OTHER THAN THE PARENTS/GUARDIANS:

NAME _____ RELATIONSHIP _____ PHONE _____

PARENT OR GUARDIAN INFORMATION

NAME _____ RELATIONSHIP _____ DOB _____

ADDRESS _____

EMAIL _____ PHONE _____ SSN _____

PARENT OR GUARDIAN INFORMATION

NAME _____ RELATIONSHIP _____ DOB _____

ADDRESS _____

EMAIL _____ PHONE _____ SSN _____

RESPONSIBLE PARTY

NAME _____ RELATIONSHIP _____ DOB _____

ADDRESS _____

EMAIL _____ PHONE _____ SSN _____

INSURANCE INFORMATION:

INSURANCE NAME: _____ ID # _____ GROUP #: _____

INSURANCE NAME: _____ ID #: _____ GROUP #: _____

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PATIENT HISTORY FORM

Patient: _____ **DOB:** _____ Date: _____

What is the reason for today's visit? _____

Who recommended the patient to be seen? _____

Who is the primary care doctor? _____ **Phone Number:** _____

Past Medical History:

Infections _____

Behavior Problems _____

Surgeries _____

Hospitalizations _____

Other _____

Social History

Smoking Exposure at Home ☐ Yes ☐ No

Does the patient smoke? ☐ Yes ☐ No

Does the patient consume alcohol? ☐ Yes ☐ No

Does the patient do drugs? ☐ Yes ☐ No

Patient's Grade _____ School _____

Does the patient have problems at school?

_____

Birth & Development

Full Term? ☐ Yes ☐ No

Birth Weight _____

Birth Complications _____

Pregnancy Issues (meds, alcohol, smoking)

Oxygen used at birth ☐ Yes ☐ No

History of Blood Transfusion? When? _____

Medications (including eye drops)? ☐ Yes ☐ No

If yes – What? _____

Allergies:

☐ None ☐ Latex

☐ Medications _____

☐ Environmental _____

What type of reaction? _____

Family History ☐ Natural ☐ Adopted

Please circle any that apply to patient's family history:

Bleeding Problems	Glaucoma	Hepatitis	Lazy Eye (Amblyopia)
Diabetes	Glasses	HIV/AIDS	Strabismus
Eye Surgery	Heart Disease	Hypoglycemia	Thyroid Disease

If any of the above are marked, please give a brief description and approximate date:

_____

_____

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CONSENT FOR TREATMENT OF A MINOR

Patient Name: _____ DOB: _____ Date: _____

I, the undersigned parent/guardian of _____, a minor, do hereby authorize and direct Carl E. Flinn, MD and the staff of Carl E. Flinn, MD to provide ongoing routine and emergency health care. This consent shall remain in effect for one year following the date on the consent form or until revoked in writing.

Parent/Guardian: _____ Date: _____

Please complete the section that applies to your situation:

1) I, the undersigned parent/guardian of _____, a minor, do hereby authorize and direct _____ to bring my child for care at Carl E. Flinn, MD. This consent shall remain in effect for one year following the date on the consent form or until revoked in writing.

   Parent/Guardian: _____ Date: _____

2) I, _____, am accompanying the minor, _____, and attest that I am his/her legal guardian.

   __ I've provided proof of guardianship __ I do not have proof of guardianship

   Parent/Guardian: _____ Date: _____

Telephone Consent – STAFF USE ONLY

I, _____, a staff member for Dr. Carl E. Flinn, spoke with _____, the parent/guardian for the minor _____ and received permission to have the patient treated by our office via a telephone conversation on _____.

Staff Member: _____ Date: _____

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PRIVACY NOTICE APPROVALS AND ACKNOWLEDGEMENTS

I, _____, HEREBY ACKNOWLEDGE THAT I HAVE BEEN MADE AWARE OF THE NOTICE OF PRIVACY PRACTICES POSTED BY DR. CARL FLINN'S OFFICE.

SIGNED: _____ DATE: _____
(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

I GIVE PERMISSION FOR DR. FLINN'S OFFICE TO CALL OR LEAVE A MESSAGE AT THE FOLLOWING:
(CIRCLE YES OR NO)

HOME # _____: YES NO

CELL # _____: YES NO

WORK # _____: YES NO

I GIVE PERMISSION FOR DR. FLINN'S OFFICE TO CONTACT ME VIA TEXT REMINDING ME OF MY UPCOMING APPOINTMENT? YES NO IF SO, CELL #: _____ Carrier: _____

I GIVE PERMISSION FOR DR. FLINN'S OFFICE TO CONTACT ME VIA EMAIL REMINDING ME OF MY UPCOMING APPOINTMENT? YES NO EMAIL ADDRESS: _____

I GIVE PERMISSION FOR DR. FLINN'S OFFICE TO TAKE MY PICTURE FOR:
ELECTRONIC MEDICAL RECORDS SOCIAL MEDIA

SIGNED: _____ DATE: _____

PLEASE PROVIDE A LIST OF ANYONE BESIDES THE PATIENT WHO HAS PERMISSION TO RECEIVE INFORMATION REGARDING ANY OF THE CONTENTS OF THEIR MEDICAL RECORDS?

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

SIGNED: _____ DATE: _____