Richard W. Quisling, M.D.
Susannah Q. Longmuir, MD

New Patient Registration Information

Date:_____

Patient Name_____ DOB_____ Age_____ Sex: M F

Address_____ City_____ State_____ Zip:_____

Home phone_____ Cell Phone: _____ E-mail_____

Marital Status: _____ SS # _____

Patient Employment Information:

Place of Employment_____

Address_____ City_____ State_____

Phone_____ ext._____ Occupation_____

If married or a minor, please answer the following:

Spouse or Parent's Name_____

Spouse or Parent's SS#_____ Date of Birth_____

Emergency Contact_____ Phone_____

Name of Referring Doctor, if any _____

Who is responsible for the bill? _____

Insurance Information: Please provide a copy of Insurance Card(s) (front and back)

I, the undersigned, authorize the release of any medical information necessary to treat me or to process the claim for services. I ask and agree that the benefits due me for my treatment be paid or assigned to the above named entities. I am responsible for any costs not covered for any reason, by my benefits, including deductibles, co-insurance and co-pays. This office will process your Primary and Secondary insurance claim, if correct information is provided.

Sign_____ date_____

I, the undersigned, understand that the above named entities will test or treat me as needed. No guarantees are made or implied regarding my treatments or the results. All the information I have provided to this office is correct. I also give permission to email, text or call me with updates to my bill or appointments.

Sign_____ date_____

Dr. Susannah Longmuir
and
Dr. Richard W. Quisling

Date: _____
Name: _____

MRN: _____ DOB: _____

- What is the reason for today's visit? _____
- Who is your primary care physician? _____ Address _____
- Referring Doctor? Same as above ☐ Name: _____ Address _____
- Mother's Name: _____ Father's Name _____

Recent Symptoms:

Yes	No		How long?	Yes	No		How long?
☐	☐	Crossed or wandering eye	_____	☐	☐	Frequent headaches	_____
☐	☐	Excessive squinting	_____	☐	☐	Red eye(s)	_____
☐	☐	Double vision	_____	☐	☐	Weakness or numbness	_____
☐	☐	Excessive eye rubbing	_____	☐	☐	Clumsiness/bumping into things	_____
☐	☐	Frequent tearing/discharge	_____	☐	☐	Can't make normal eye contact	_____
☐	☐	Blurred vision	_____	☐	☐	Change in performance in school	_____
☐	☐	Light sensitivity	_____	☐	☐	Other symptoms	_____

History of Eye Problems: Has the patient had any of the following?

Yes	No		Age	Yes	No		Age
☐	☐	Eye Exam	___	☐	☐	Eye injury	___
☐	☐	Glasses	___	☐	☐	Eye surgery	___
☐	☐	Patching	___	☐	☐	Other eye problems	___

Explanations: _____

Birth & Social History:

Yes	No		Yes	No	
☐	☐	Problems during pregnancy	☐	☐	Delivered more than 2 weeks early or late
☐	☐	Problems during delivery or forceps delivery	☐	☐	Baby kept in hospital due to illness
☐	☐	Cesarean section	☐	☐	Delayed development

With whom does your child primarily reside? ☐Mother and/or Father; Other: _____

Explanations: _____

Other Medical Problems: (Medical History and Review of Systems)

Yes	No		Yes	No	
☐	☐	Fever or weight loss	☐	☐	Skin rash
☐	☐	Frequent ear infections	☐	☐	Neurological problems
☐	☐	Other ear, nose or throat problems	☐	☐	Mental illness
☐	☐	Heart problems	☐	☐	Sickle cell disease
☐	☐	Lung disease	☐	☐	Missing immunizations
☐	☐	Kidney or urinary disease	☐	☐	Environmental allergies
☐	☐	Arthritis			

Explanations: _____

- List any previous **surgery**, **hospitalizations**, **major illnesses**, or **injuries** (other than eye problems): _____
- List any **medications** the patient is taking, including **eye drops**: _____
- List any **ALLERGIES** to medications: ☐ None _____

Family History: Have the patient's relatives have had any of the following?

Yes	No		Relative	Yes	No		Relative
☐	☐	Blindness	_____	☐	☐	Cataracts in childhood	_____
☐	☐	Amblyopia (lazy eye)	_____	☐	☐	Glaucoma in childhood	_____
☐	☐	Patching treatment	_____	☐	☐	Other eye disease	_____
☐	☐	Strabismus (misaligned eye)	_____	☐	☐	Complications from anesthesia	_____
☐	☐	Eye muscle surgery	_____	☐	☐	Genetic disease (runs in family)	_____
☐	☐	Glasses before age 6	_____	☐	☐	Other serious illnesses	_____

Physician Reviewed: _____ MD Date _____
Reviewed and Updated: _____ MD Date _____
Reviewed and Updated: _____ MD Date _____
Reviewed and Updated: _____ MD Date _____
Reviewed and Updated: _____ MD Date _____

RICHARD W. QUISLING, M.D., P.C.
Richard W. Quisling, M.D.
SUSANNAH QUISLING LONGMUIR, M.D., P.C.
Susannah Quisling Longmuir, M.D.

ATTENTION: OFFICE POLICY REGARDING EMERGENCY CARE AND/OR TREATMENT

The doctor patient relationship for the offices of Richard W. Quisling, M.D., P.C. (Richard W. Quisling, M.D.) and/or Susannah Quisling Longmuir, M.D., P.C. (Susannah Quisling Longmuir, M.D.) does not provide total coverage after hours and weekends or Holidays for emergency treatment and in situations where the informed consent for the most effective form of treatment would include tertiary/hospital, hospitals, or emergency care. Dr. Quisling provides a family practice type otolaryngology/ENT service and Dr. Longmuir provides a family practice type ophthalmology service. The care of these doctors is limited to treating medically with minor surgical procedures and/or vocal care and treatment of eye disease and discomfort. If you feel you have a medical emergency, call 911 or go to the nearest Emergency Room. Both Dr. Quisling and Dr. Longmuir can be reached through their answering service but neither ENT nor EYE coverage can be guaranteed for emergencies.

I have read, understand, and accept the above statement and realize that in the event I feel that I have a medical emergency, it is my responsibility to seek emergency advice and care in a hospital emergency room or clinic. I will not hold either Dr. Quisling or Dr. Longmuir responsible for any outcome in my regard due to my inability to reach him or her should that be the case.

Signature of patient_____date_____

Print name_____

Signature of witness_____ date_____

Susannah Longmuir MD PC
Richard W. Quisling MD PC
593 Stewarts Ferry Pike
Nashville, TN 37214

PARENTS: READ THIS ABOUT YOUR CHILD'S EYE OR ENT EXAM

Patient Name: _____ Date: _____

At the request of the pediatrician caring for your child, a medical exam will be performed on your child.

This office is dedicated to helping your child obtain the treatment needed for his or her eye condition or ENT (ear, nose and throat) condition. It is very important to bring your child' to recommended exams and fill any glasses prescriptions that are possibly needed or perform any eye or ear drops may be prescribed by the doctor. Children have a developing visual system and treatment for eye conditions must occur before the visual system is mature. Hearing loss that is not treated can also cause language delay. Ear infections that are not treated in a timely manner can also lead to hearing loss.

I am aware that the office will help me to make appointments, and remind me of them when possible, but that ultimately the responsibility of making and keeping these follow up appointments is mine alone.
I understand that my child has a potentially serious ear, nose or throat or eye condition that can lead to vision loss or hearing loss if untreated or timely follow up does not occur. I take the responsibility for visiting an ophthalmologist or otolaryngologist at the recommended time.

Parent or Guardian Signature _____
Relationship to Patient_____ Date _____

Health Care Practitioner Signature _____
Date_____

Richard Quisling, M.D. P.C.
& Susannah Longmuir, M.D.
Patient Consent for Use and Disclosure
of Protected Health Information

I hereby give my consent for Dr. Richard Quisling and Dr. Susannah Longmuir to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by Dr. Richard Quisling and Dr. Susannah Longmuir describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Richard Quisling and Dr. Susannah Longmuir reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Richard Quisling and Dr. Susannah Longmuir.

With this consent, Dr. Richard Quisling and Dr. Susannah Longmuir may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Dr. Richard Quisling and Dr. Susannah Longmuir may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Dr. Richard Quisling and Dr. Susannah Longmuir may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Richard Quisling restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Dr. Richard Quisling and Dr. Susannah Longmuir to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Richard Quisling and Dr. Susannah Longmuir may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

Richard W. Quisling, M.D. & Richard W. Quisling, M.D.,P.C.
Susannah Q. Longmuir, M.D. & Susannah Quisling Longmuir, M.D., P.C.

Consent for Treatment

I, _____ understand and agree that Richard W. Quisling, M.D. and Richard W. Quisling, M.D., P.C. and/or Susannah Q. Longmuir, M.D., and Susannah Q. Longmuir, M.D., P.C. may test or treat me as needed.

I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do so refuse. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. No guarantees were made to me about the results of my treatment.

If I have questions or concerns about any of the above, I will speak with the doctor (s) before care is provided.

Agreement to Pay: By signing this document, I agree that: All the information I have given you is correct. The doctor may release or share any information needed to process my claims. Those providing my care shall be paid or assigned benefits on my behalf. I will co-operate with and provide documentation requested by my insurance company or other payer necessary to process my claims. I am responsible for any costs not covered by my benefits, including non-covered services, deductibles, and co-insurance, and co-pays.

Please Note: by signing this agreement, I understand that I may see either doctor herein named, but that it is not necessary that I see both doctors. I realize that, while the doctors may share a waiting room, that each is a separate medical office with separate business systems and separate billing. I am responsible for my co-pays and deductibles as billed by the treating doctor individually. The treating doctor will be identified on my bill or my insurance form as the treating doctor the rendering doctor and as the billing doctor.

Assignments of Benefits: If Dr. Quisling or Dr. Longmuir is in position to accept my insurance, I ask and agree that any benefits due to me for my treatment by all insurance companies or other third party payers responsible for my care shall be paid or assigned to the billing doctor. This includes any settlements related to the reason for my treatment. These benefits shall not be more that the charges for my treatment. If my insurance company or other payer will not pay the doctor directly for my care and treatment, I will immediately forward payments I receive to my doctor, Dr. Quisling or my doctor, Dr. Longmuir.

Non-covered services: I understand that my insurance or payer may not cover all my costs. I agree that I am personally responsible for any costs not covered by my insurance or payer.

Guarantor Agreement: I, or the person signing or guaranteeing payment for me or my child, am responsible for any charges not covered by my insurance, for any reason. Such charges are due when my treatment is stopped or I am discharged. I understand that I may not receive a bill and realize that it is my responsibility to check with the office of the doctor to see if I have any current or past due amounts owed. The doctors or their offices may also may bill my insurance for me. But either doctor or his or her office may also ask for payment in full, in advance, unless the doctor agrees with my insurance company or other payer not to do so.

I understand and agree that the above applies to any minor child I may have or have custody of, who is being treated by Richard W. Quisling, M.D. or Susannah Q. Longmuir, M.D. or their individual offices.

Signed_____ date_____

Relationship to patient: Self or Guarantor: _____