Dr. _____ Date _____ Time _____ Patient # _____

PATIENT INFORMATION:

Name _____ Sex: M ☐ F ☐ Date of Birth: _____/_____/_____

Address _____ **eMail*: _____
Street City State Zip

Social Security # _____-_____-_____ Home Phone _____ Emerg. Phone _____

Use/Interested in contacts? Yes ☐ No ☐

Reason for Visit _____

Were you referred to our office by another doctor? No ☐ Yes ☐ - Dr. _____

Family doctor: _____ **Preferred Pharmacy* _____ Address _____

PRIMARY INSURANCE INFORMATION:

Insurance Company Name _____

Name of Subscriber _____ Relationship to Patient _____

Date of Birth: _____/_____/_____ Social Security # _____-_____-_____ Employed? Yes ☐ No ☐

Employer _____ Employer Phone _____

I acknowledge receipt of the document titled "Notice of Privacy Practices."

Signature _____

Date _____

Kentucky Eye Institute complies with the FTC "Red Flag" identity theft regulations.

If you are covered by Medicare and a Group Health Insurance, please complete this section. Are you or your spouse still employed? Yes ☐ No ☐ If yes, does the employer have (check one) ☐20 or more employees ☐100 or more employees? Are you entitled to Medicare as a result of a disability? Yes ☐ No ☐ Are you entitled to Medicare due to renal disease? Yes ☐ No ☐

INSURANCE AUTHORIZATION: I request payment of all authorized benefits be made on my behalf to KEI for any services I receive from any KEI doctor. I authorize any holder of medical information about me to release information as needed to determine these benefits or the benefits for related services to my insurance company(ies) and their agent(s), including the Centers for Medicare and Medicaid Services (CMS) if I have Medicare/Medicaid coverage. I understand that I am responsible for all deductibles, co-pays, non-covered services, and the 20% Medicare does not pay (if applicable).

_____ _____
Patient/Responsible Party Signature Date

PAST DUE ACCOUNTS: I understand that interest will be charged on accounts that are 90 days or more past due. If KEI turns my account over to a collection agency, I understand that the collection agency will add interest of 1 1/2 % per month (18% per year) to any unpaid balances. Except for emergencies, if my account has been turned over for collection, I may only schedule future KEI appointments if I pay: for future services in advance, unpaid balances, and collection agency commission and/or legal fees paid by KEI to collect my delinquent account.

_____ _____
Patient/Responsible Party Signature Date

☐ Appointment in Computer ☐ Information in Computer ☐ ROS & New Patient Sheets Mailed 012016

KENTUCKY EYE INSTITUTE CONSENT FOR PATIENT CONTACT

From time to time, it may be necessary for Kentucky Eye Institute to contact you concerning a variety of issues that pertain to your medical care. While the following list is not all-inclusive, we might need to contact you to:

- Make an appointment
- Cancel an appointment
- Inform you that your glasses or contact lenses are ready to be picked up
- Discuss your medical care and treatment

To assist you with your needs and to address the patient privacy issues described in the Health Insurance Portability and Accountability Act of 1996, we need you to specify the alternative ways we may contact you in the event we cannot reach you personally.

You may contact me by: (please check any box(es) that apply)

- ☐ Leaving a message on my home answering machine
- ☐ Leaving a message on my work answering machine
- ☐ Emailing me at home _____
- ☐ Emailing me at work _____
- ☐ Leaving a message with anyone who answers my telephone at home
- ☐ Leaving a message with anyone who answers my telephone at work
- ☐ U.S. mail
- ☐ Other (specify) _____

In the event you cannot contact me personally, you may discuss my care with any of the following individuals:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

☐ No one

I give my consent for any representative of KEI to contact me regarding my care using the means I have indicated by the checked boxes above. Further, I give my permission to discuss my care with the individuals whose names are listed.

_____ _____

Patient's Signature Date

Review of Systems

Please check all that apply:

- ☐ Poor vision
- ☐ Eye pain
- ☐ Tearing
- ☐ Redness
- ☐ Jaw pain
- ☐ Scalp tenderness
- ☐ Amaurosis fugax
- ☐ Loss of vision
- ☐ High blood pressure
- ☐ Congestion
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Arthritis
- ☐ Diabetes
- ☐ Allergies
- ☐ Fever
- ☐ Chills
- ☐ Weight loss
- ☐ Stuffy nose
- ☐ Earache
- ☐ Cough
- ☐ Dry mouth
- ☐ Rapid heart beat
- ☐ Upset stomach
- ☐ Diarrhea
- ☐ Constipation
- ☐ Burning on urination
- ☐ Urinary frequency
- ☐ Incontinence
- ☐ Joint pain
- ☐ Stiffness
- ☐ Rash
- ☐ Changing moles
- ☐ Headache
- ☐ Seizure
- ☐ Stroke
- ☐ Paralysis
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Thyroid abnormalities
- ☐ Bleeding
- ☐ Anemia
- ☐ Hay fever
- ☐ Hives

Name:	Date:

PAST MEDICAL HISTORY: Check any you have/have had OR check here if None ☐

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Bone Marrow Transplantation
- ☐ BPH (Enlarged Prostate)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD (Chronic Breathing Problems)
- ☐ Coronary Artery Disease (Heart Disease)
- ☐ Depression
- ☐ Diabetes: How long? _____ years
  Dr.?_____ Where?_____
- ☐ End Stage Renal Disease
- ☐ GERD (Acid Reflux)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension (High Blood Pressure)
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia (High Cholesterol)
- ☐ Hyperthyroidism (Overactive Thyroid)
- ☐ Hypothyroidism (Underactive Thyroid)
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke

☐ Other

Past Surgeries: Check any you have had OR check here if None ☐

- ☐ Appendix
- ☐ Bladder
- ☐ Breast: (Circle One) Mastectomy, Lumpectomy, Biopsy, Reduction, Implants : Right or Left
- ☐ Colon: (Circle One) Cancer, Diverticulitis, Inflammatory Bowel Disease, Other
- ☐ Gallbladder
- ☐ Heart: (Circle One) Bypass Surgery, Stents, Catheterization, Angioplasty, Valve Replacement, Transplant, Other
- ☐ Joint Replacement: (Circle One) Knee: Right or Left; Hip: Right or Left
- ☐ Kidney: (Circle One) Biopsy, Removal, Stone Removal, Transplant, Other
- ☐ Ovaries: (Circle One) Endometriosis, Cyst, Cancer, Other
- ☐ Prostate: (Circle One) Cancer, Biopsy, TURP, Other
- ☐ Skin: (Circle One) Skin Biopsy, Basal Cell, Squamous, Melanoma
- ☐ Spleen
- ☐ Testicles: (Circle One) Removal, Cancer
- ☐ Uterus: (Circle One) Fibroids, Hysterectomy, Cancer, Other

☐ Other

OCULAR HISTORY: Check Left, Right, or Both for any you have/have had OR Check here if None ☐

- ☐ Allergic Conjunctivitis (Pink Eye) ☐R ☐L ☐B
- ☐ Blepharitis ☐R ☐L ☐B
- ☐ Cataract ☐R ☐L ☐B
- ☐ Contact Lenses ☐R ☐L ☐B
- ☐ Corneal Dystrophy ☐R ☐L ☐B
- ☐ Diabetic Retinopathy ☐R ☐L ☐B
- ☐ Dry Eyes ☐R ☐L ☐B
- ☐ Glasses
- ☐ Glaucoma ☐R ☐L ☐B
- ☐ Macular Degeneration ☐R ☐L ☐B
- ☐ Narrow Angles ☐R ☐L ☐B
- ☐ Ocular Hypertension ☐R ☐L ☐B
- ☐ Ocular Migraine
- ☐ Retinal Tear ☐R ☐L ☐B
- ☐ Strabismus (Eye Muscle Misalignment) ☐R ☐L ☐B
- ☐ Vitreous Floaters ☐R ☐L ☐B

☐ Other

Patient Name:	Date:

*** * * COMPLETE BOTH SIDES * * ***

Ocular Surgery: Check any you have had OR check here if None ☐

☐ Blepharoplasty ☐R ☐L ☐B	☐ LPI (Laser for Narrow Angles) ☐R ☐L ☐B
☐ Cataract Surgery ☐R ☐L ☐B	☐ LTP (Laser for Open Angle Glaucoma) ☐R ☐L ☐B
☐Corneal Transplant ☐R ☐L ☐B	☐ Ptosis Repair ☐R ☐L ☐B
☐ Eye Muscle Surgery ☐R ☐L ☐B	☐ Punctal Plugs ☐R ☐L ☐B
☐ Intravitreal Injections ☐R ☐L ☐B	☐ Retinal Laser ☐Diabetes/☐Tear ☐R ☐L ☐B
☐ LASIK (Refractive Laser) ☐R ☐L ☐B	☐ YAG Capsulotomy ☐R ☐L ☐B
☐ Other	

Family History: Check any for which you have an immediate family history OR check here if None ☐

☐ Blindness	☐ Heart Disease
☐ Cancer	☐ Hypertension (High Blood Pressure)
☐ Cataracts	☐ Macular Degeneration
☐ CVA (Stroke)	☐ Migraines
☐ Diabetes	☐ Retinal Detachment
☐ Glaucoma	☐ Strabismus
☐ Other	

MEDICATIONS: List below (prescribed, non-prescribed, and over-the-counter) OR check here if None ☐

ALLERGIES: List below OR check here if None ☐

SOCIAL HISTORY: Check any that apply.

☐ Illegal Drug Use	Alcohol Use: Check one. ☐ None ☐ 1 to 2 drinks/day ☐ Less than 1 drink/day ☐ 3 or more drinks/day

Smoking Status: Check one.	**Driving Status:** Check one.
☐ Current every day smoker	☐ Drive daytime
☐ Current occasional smoker	☐ Drive nighttime
☐ Former smoker	☐ Drive daytime and nighttime
☐ Never smoked	☐ Do not drive

Occupation: Check here if retired ☐	**Workplace:**

Race/ethnicity patient information is a Medicare requirement for practices using electronic health records.

Race:	**Ethnicity:**
☐ White	☐Hispanic or Latino
☐ American Indian/Alaska Native	☐Not Hispanic or Latino
☐ Asian	**Preferred Language:**
☐ Black or African American	☐English
☐ Native Hawaiian or other Pacific Islander	☐Other _____
☐ Other race _____	

* * * COMPLETE BOTH SIDES * * *

Reviewed _____ _____