

WELCOME TO



FOR PEOPLE WHO SEE THE DIFFERENCE

DATE _____

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE: HOME _____ WORK _____ OTHER _____

SOCIAL SECURITY NO. _____ - _____ - _____ DATE OF BIRTH _____

OCCUPATION _____

EMPLOYER _____

GENDER M _____ F _____

EMERGENCY CONTACT / TELEPHONE NUMBER _____

NAME OF PARENT OR SPOUSE _____

PERSON RESPONSIBLE FOR PAYMENT _____

METHOD OF PAYMENT: INSURANCE MEDICARE MEDICAID CHECK CASH CREDIT CARD

HAVE WE SEEN ANY OTHER FAMILY MEMBERS: YES NO

IF YES, WHOM _____

HOW DID YOU HEAR ABOUT OUR OFFICE:

MAIL OUTS NEWSPAPER TELEPHONE BOOK FAMILY FRIEND LOCATION

— MEDICAL INFORMATION —

WHAT IS YOUR GENERAL HEALTH? _____

DO YOU HAVE PROBLEMS WITH ANY OF THESE SYSTEMS? (PLEASE CHECK ALL THAT APPLY)

EYES YES NO

GASTROINTESTINAL YES NO

EAR / NOSE / THROAT .. YES NO

CARDIOVASCULAR YES NO

RESPIRATORY YES NO

NERVOUS YES NO

GENITOURINARY YES NO

MUSCULOSKELETAL ... YES NO

INTEGUMENTARY (SKIN) .. YES NO

MENTAL YES NO

ENDOCRINE (GLANDS) YES NO

BLOOD / LYMPH YES NO

ALLERGIC / IMMUNOLOGIC ... YES NO

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE EXPLAIN _____

– MEDICAL INFORMATION CONTINUED –

PLEASE ANSWER ALL THAT APPLY:

DIABETES: YES NO TYPE _____ DATE OF DIAGNOSIS _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO WHAT MEDICATION? _____

OTHER HEALTH PROBLEMS _____

CURRENT MEDICATIONS _____

HAVE YOU EVER HAD ANY OPERATIONS? YES NO KIND? _____

DO YOU USE CIGARETTES / TOBACCO? _____ ALCOHOL? _____ OTHER SUBSTANCE (S)? _____

NAME OF FAMILY DOCTOR _____ DATE OF LAST VISIT _____

DATE OF LAST TETANUS SHOT _____

– FAMILY HISTORY –

CATARACTS? YES NO RELATION _____

MACULAR DEGENERATION? YES NO RELATION _____

DIABETES? YES NO RELATION _____

RETINAL DETACHMENT? YES NO RELATION _____

GLAUCOMA? YES NO RELATION _____

OTHER EYE CONDITION? YES NO RELATION _____

IF YES WHAT KIND _____

– PERSONAL EYE INFORMATION –

DATE OF LAST EYE EXAM _____ DILATED ? _____

HAVE YOU HAD ANY EYE OPERATIONS? YES NO

IF YES, TYPE _____ DATE _____

HAVE YOU HAD AN EYE INJURY? YES NO

IF YES, KIND _____ DATE _____

DO YOU HAVE GLAUCOMA? YES NO

DO YOU HAVE DRY EYES? YES NO

DO YOU HAVE CATARACTS? YES NO

DO YOU HAVE BLURRED VISION? YES NO

DO YOU HAVE OTHER EYE PROBLEMS? YES NO

DO YOU HAVE MACULAR DEGENERATION? YES NO

IF YES, WHAT KIND _____

DO YOU WEAR GLASSES? YES NO

DO YOU WEAR CONTACT LENSES? YES NO

IF CONTACT LENSES, WHAT BRAND? _____

ADDITIONAL INFORMATION _____

PATIENT'S SIGNATURE _____ **DOCTOR'S INITIALS** _____

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Kilgore Eye Care Center make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- I have read or had explained to me Kilgore Eye Care Center's Notice of Privacy Practices and agree to continue my care with Kilgore Eye Care Center under said terms.
- I was given the opportunity to read Kilgore Eye Care Center's Notice of Privacy Practices and declined, but wish to continue my care with Kilgore Eye Care Center under the terms of Kilgore Eye Care Center's privacy policies.
- I have read or had explained to me Kilgore Eye Care Center's Notice of Privacy Practices and do not wish to continue my care with Kilgore Eye Care under said terms.
- The Notice of Privacy Practices could not be read due to the emergent nature of the care of other reason described as:

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient

Date

If you are signing as a personal representative of the patient, please indicate your relationship.

Representative

Relationship to Patient

Authorization To Release Information/Assignment Of Benefits

*Primary Insurance_____

Subscribers Name_____

Subscribers Date Of Birth_____ SS#_____

Subscribers Relationship To Patient_____

*Secondary Insurance_____

Subscribers Name_____

Subscribers Date Of Birth_____ SS#_____

Subscribers Relationship To Patient_____

I request that payment of authorized Medicare, Medigap, Medicaid, Private or Commercial Insurance benefits be made on my behalf to Kilgore Gilmer Mt. Pleasant Eye Care Centers or any Physician of that group. I authorize the Eye Care Centers to release to my insurance company, any information needed to determine these benefits payable for related services. I will be financially responsible for all charges not covered by my insurance policy. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Signature

Date