Kelly eye center *for sight*

Main Office: 919-282-1100

Patient Name_____ **Date of Birth** _____

Nickname/Pronunciation, if applicable _____

SS# _____ **Sex: M F Marital Status: S M W D Other**_____

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Decline to answer/other/unknown

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to answer/other/unknown

Language Preference:

- ☐ English
- ☐ Spanish
- ☐ Other

Address_____

City_____ **State**_____ **Zip**_____

Primary Phone_____ **Work Phone**_____ **ext.**_____

Secondary Phone _____ **Email Address:** _____

Emergency Contact Name _____ **Phone** _____

Responsible Party if other than patient: _____

Address: _____

Primary Insurance_____ **Secondary Insurance**_____

Name of Pharmacy: _____ **Address or Telephone** _____

How did you hear about us? _____

If you were referred by a doctor, what is the doctor's name? _____

Signature: _____ **Date:** _____

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. You will be required to pay this at each visit.
2. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

PATIENT HISTORY INFORMATION

Name: _____ Date of Birth: _____

Family Doctor: _____ Eye Doctor: _____

Please answer the following questions about your medical status and history.

Height_____ Weight_____ Have you fallen in the last year? □ Yes □ No

Smoking status: □ Current smoker □ Former smoker □ No smoking history

Do you drink alcohol? □ Yes □ No If yes, how much? _____

Do you drive? □ Yes □ No If no, when/why did you stop? _____

Do you live alone? □ Yes □ No □ Nursing Home

Females, are you pregnant? □ Yes □ No Breast feeding? □Yes □ No

Have you ever been treated for any of the following medical conditions? Please check yes or no and circle all that apply. Explain further in the space provided, if necessary.

□ Yes □ No Ear, Nose, Throat (hearing loss, sinus disease, vertigo, tinnitus)_____

□ Yes □ No Cardiovascular (heart attack, stroke, angina, murmur, mitral valve prolapse, high BP, high cholesterol)

_____

□ Yes □ No Lung Disease (COPD, asthma, TB, pneumonia)_____

□ Yes □ No Skin Diseases (rosacea, dermatitis, psoriasis)_____

□ Yes □ No Gastrointestinal Disease (ulcers, hernia, reflux, intestinal or liver disease)_____

□ Yes □ No Genitourinary Disease (kidney disease, dialysis, kidney stones)_____

□ Yes □ No Thyroid Disease (hypo, hyper, Graves disease)_____

□ Yes □ No Diabetes (Type I or Type II) _____

□ Yes □ No Neurological (MS, neuropathy, paralysis) _____

□ Yes □ No Mental Health (depression, anxiety, bipolar, dementia)_____

□ Yes □ No Blood Diseases (anemia, clotting disease)_____

□ Yes □ No Arthritis (rheumatoid, osteo-degenerative)_____

□ Yes □ No Cancer (list type or location and date)_____

□ Yes □ No Infectious Disease (TB, syphilis, gonorrhea, AIDS, HIV, hepatitis)_____

PREVIOUS SURGERY (Example: heart stent 2002, appendectomy 1997)**:** _____

_____

Do you <u>currently</u> have any of the following problems? Please check yes or no, and <u>circle which condition you're presently experiencing.</u>

□ Yes □ No Weakness, numbness, headaches

□ Yes □ No Sore throat, ear pain, sinus problems

□ Yes □ No High blood pressure

□ Yes □ No Chest pain, palpitations

□ Yes □ No Shortness of breath, wheezing, coughing (respiratory)

□ Yes □ No Rashes, excessive dryness

□ Yes □ No Heartburn, abdominal pain, diarrhea, vomiting

□ Yes □ No Pain with urination, blood in urine

□ Yes □ No Abnormal thyroid level

□ Yes □ No Depression/anxiety

□ Yes □ No Easy bruising (hematological)

□ Yes □ No Joint pain (musculoskeletal)

EYE HISTORY

Have you ever had any of the following? If yes, please explain and include dates.

□ Yes □ No Eye surgery or Laser _____

□ Yes □ No Contact lenses _____

Eye Drops: _____

Have you ever been diagnosed with any eye disease? If yes, please explain and include the year diagnosed.

□ Yes □ No Cataract _____

□ Yes □ No Corneal Disease or Transplant _____

□ Yes □ No Diabetic Eye Disease _____

□ Yes □ No Glaucoma _____

□ Yes □ No Lazy Eye (Amblyopia) _____

□ Yes □ No Macular Degeneration _____

□ Yes □ No Retinal Detachment or Hole _____

□ Yes □ No Injury _____

Other_____

FAMILY HISTORY OF DISEASE

Do you have immediate family history of any of the following? Please indicate which relative is/was affected (Example: mother, father, sister, brother, daughter, or son):

□ Yes □ No Glaucoma _____

□ Yes □ No Retinal Disease _____

□ Yes □ No Diabetes _____

□ Yes □ No Heart Disease _____

□ Yes □ No Cancer _____

MEDICATION	DOSAGE (including milligrams and how often you take it)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

MEDICATION	DOSAGE (including milligrams and how often you take it)
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	

ALLERGIES (medication or food)	REACTION

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Patient Signature: _____ **Date:** _____

Receipt of Notice of Privacy Policies & Consent Form

Patient Name: _____ Date of Birth: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices***.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Kelly Eye Center.

_____ _____

Signature Date

If **Parent/Guardian** or **Power of Attorney** of the patient, please complete the following section:

_____ _____

Relationship to Patient Print Name

_____

Source of Authority