eye associates
SEETHECLARITY.COM

Overland Park Olathe Shawnee Leawood
Prairie Village South Olathe South Overland Park

How Were You Referred To Our Office?

Friend/Relative Name_____ Insurance Office Sign
Other_____ Internet: Google, Yelp, Facebook Yellow Pages

Personal Information

Name_____ Date_____
Address_____
City_____ State_____ Zip_____
Phone: Cell_____ Home_____ Work_____
Date Of Birth_____ Age_____ Occupation _____ Gender M / F
SS#_____ Email_____

Responsible Party / Primary Insurance Holder (if other than above)

Name_____ Date_____
Address_____
City_____ State_____ Zip_____
Phone: Cell_____ Home_____ Work_____
Date Of Birth_____ Age_____ Occupation _____ Gender M / F
SS#_____ Email_____

Reason For Visit

Regular Eye Exam	Y / N	Redness / Pain	Y / N	Blurred Vision	Y / N	Glasses Needed	Y / N
Medical Exam	Y / N	Itching / Gritty	Y / N	Dry Eye	Y / N	Contacts Needed	Y / N
Headaches	Y / N	Flashes	Y / N	Other _____			

Date of last exam_____ Name of last doctor_____
Do you presently wear? Glasses Y / N Contacts Y / N Type of contacts worn_____
If no to contacts, would you be interested in them? Y / N

Lifestyle Information

How much time are you spending on the computer, tablet, and/or phone? _____ Hours
Does night driving bother you? Y / N Are you happy with your current contact brand? Y / N
Are you happy with your current glasses? Y / N Are you interested in daily disposable contacts? Y / N
Are you happy with your sunglasses? Y / N

Social History

This information is kept strictly confidential. You may discuss this portion with the Doctor if you prefer.

Do you consume alcohol? Y / N How much?_____ How long?_____

Do you use tobacco products? Y / N How much?_____ How long?_____

Do you use illicit drugs? Y / N How much?_____ How long?_____

Medical and Vision History

Medication_____ For what purpose?_____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Surgeries_____ _____

_____ _____

_____ _____

Drug Allergies_____

Health	Self	Family	Health	Self	Family	Health	Self	Family
Allergies	Y / N	Y/ N	Diabetes: I or II	Y / N	Y/ N	Macular Degeneration	Y / N	Y/ N
Blindness	Y / N	Y/ N	Glaucoma	Y / N	Y/ N	Migraines	Y / N	Y/ N
Cancer	Y / N	Y/ N	Heart Disease	Y / N	Y/ N	Neurological	Y / N	Y/ N
Cataracts	Y / N	Y/ N	High Cholesterol	Y / N	Y/ N	Respiratory	Y / N	Y/ N
Detached Retina	Y / N	Y/ N	Hypertension	Y / N	Y/ N	Thyroid	Y / N	Y/ N

Patient Financial Consent and Acknowledgement of Receipt of Privacy Practices

(Failure to give consent prevents our offices from participating with most insurance plans.)

Patient Name_____ Date of Birth_____

I give Eye Associates consent to release pertinent medical records to my insurance company for treatment, payment, and health care operations including and not limited to provider functions and the quality assessments. I understand that my medical records are confidential. I also understand that I may revoke the written consent by written request at any time. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made by my consent.

I have read the statement above and in signing this document give my consent to release my medical records and information. I do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this consent. It is customary to pay the office services at the time of each visit, unless previous arrangements have been made. If we are accepting insurance it will be necessary for you to pay your portion of the services and material fees at the time of your initial visit. Your insurance company does not guarantee benefits. Payment is only determined at the time of claim's processing. In the event that your insurance company denies the claim, you will be responsible for the balance of the charges.

Please note that there is a $20 service charge on all returned checks.

I (have received/ or do not want) a copy of Eye Associates' Notice of Privacy Practices with an effective date of April 8, 2013.

Name_____ Signature_____ Date_____

Name of Witness (Eye Associates' Employee)_____ Date_____