



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 \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_  
Date Of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender M / F  
SS# \_\_\_\_\_ Email \_\_\_\_\_ Occupation \_\_\_\_\_

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

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_  
Date Of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender M / F  
SS# \_\_\_\_\_ Email \_\_\_\_\_ Occupation \_\_\_\_\_

### 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

### Life Style 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 current 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 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 claims 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 \$20.00 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 January 21, 2003.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Name of Witness (Eye Associates Employee) \_\_\_\_\_ Date \_\_\_\_\_