



Overland Park Olathe Shawnee Leawood

Dr. Pennipede Dr. Davis Dr. Siefkes Dr. Noyce Dr. Bartimus Dr. Beedles Dr. Coleman Dr. Honeyman

How Were You Referred To Our Office?

Friend/Relative Name Insurance Office sign
Other Internet Yellow Pages

Personal Information

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

Primary Insurance Holder / Responsible Party (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 contactsworn
If no to contacts would you be interested in them? Y / N

Life Style Information

How much time are you spending on the computer? 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 happy with your current sunglasses? Y / N
Does glare bother you? 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? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Surgeries \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Drug Allergies \_\_\_\_\_

Health	Self	Family	Health	Self	Family	Health	Self	Family
Allergies	Y / N	Y / N	Glaucoma	Y / N	Y / N	Neurological	Y / N	Y / N
Cataracts	Y / N	Y / N	Hay Fever	Y / N	Y / N	Respiratory	Y / N	Y / N
Detached Retina	Y / N	Y / N	HBP	Y / N	Y / N	Thyroid	Y / N	Y / N
Diabetes	Y / N	Y / N	Heart Disease	Y / N	Y / N			
Dry Mouth	Y / N	Y / N	Migraines	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 \_\_\_\_\_

