WELCOME TO OUR OFFICE

NAME _____ DATE _____

EMPLOYER _____ OCCUPATION _____ HOBBIES _____

WHAT IS THE MAIN PURPOSE OF THIS VISIT? _____

ANY PROBLEMS WITH YOUR PRESENT GLASSES OR CONTACT LENSES? _____

VERY IMPORTANT!

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

IF NOT REFERRED, HOW DID YOU CHOOSE OUR OFFICE FOR YOUR NEEDS?

☐ ANOTHER DR. ☐ INSURANCE LISTING ☐ SAW SIGN/BUILDING
☐ NEWSPAPER ☐ WEB PAGE ☐ OTHER: _____

DO YOU PARTICIPATE IN A FLEX SPENDING ACCOUNT? ☐ YES ☐ NO

HOW WILL YOU SETTLE YOUR ACCOUNT TODAY? (CIRCLE ONE) ☐ CASH ☐ CHECK ☐ CREDIT CARD

DO YOU EXPERIENCE... (CHECK BOX IF YOUR ANSWER IS YES)

☐ BLURRY VISION
☐ BURNING
☐ TEARING
☐ HEADACHES
☐ DOUBLE VISION
☐ FLASH OF LIGHT
☐ FLOATERS/SPOTS
☐ GRITTINESS
☐ ITCHINESS
☐ DRY EYES
☐ SUNLIGHT SENSITIVITY
☐ POOR NIGHT VISION
☐ UNCOMFORTABLE GLASSES

HAVE YOU BEEN DIAGNOSED WITH OR TREATED FOR...

☐ CATARACTS
☐ CORNEAL ABRASION
☐ EYE INFECTION
☐ EYE INJURY
☐ GLAUCOMA
☐ IRITIS/UVEITIS
☐ LAZY EYE
☐ MACULAR DEGENERATION
☐ RETINAL DETACHMENT
☐ DIABETIC RETINOPATHY
☐ DRY EYE DISEASE
☐ BLEPHARITIS

DATE OF LAST EYE EXAM: _____ BY WHOM? _____

DO YOU CURRENTLY WEAR CONTACT LENSES? ☐ YES ☐ NO

WHAT KIND? _____ SOLUTION USED: _____

WOULD YOU PREFER CLEAR CONTACT LENSES, OR COLORED CONTACT LENSES? ☐ CLEAR ☐ COLORED

HAVE YOU EVER TRIED CONTACT LENSES? ☐ YES ☐ NO

DO YOU .... (CHECK BOX IF YOUR ANSWER IS YES)

☐ WORK AT THE COMPUTER?
☐ THINK YOU MIGHT BENEFIT FROM THINNER, LIGHTER LENSES?
☐ HAVE INTEREST IN A TEST DRIVE OF THE LATEST CONTACT LENS DESIGNS?
☐ SPEND TIME OUTDOORS? IF SO, HOW MANY HOURS PER DAY: _____
☐ HAVE PRESCRIPTION SUNGLASSES?
☐ PREFER NOT TO WEAR YOUR GLASSES AT TIMES?
☐ WANT INFORMATION ON LASER VISION CORRECTION SURGERY?
☐ HAVE MORE THAN 1 PAIR OF CURRENT PRESCRIPTION GLASSES?
☐ HAVE CHILDREN?
☐ HAVE A FAMILY MEMBER IN NEED OF EYECARE?

IS THERE A **FAMILY MEDICAL** HISTORY OF ANY OF THE FOLLOWING? **(CHECK ALL THAT APPLY)**

☐ BLINDNESS
☐ CATARACTS
☐ CORNEAL PROBLEMS
☐ GLAUCOMA
☐ LAZY EYE
☐ MACULAR DEGENERATION
☐ RETINAL PROBLEMS
☐ OTHER EYE DISEASE: _____
☐ DIABETES
☐ HEART DISEASE
☐ STROKE
☐ HIGH BLOOD PRESSURE

HEALTH HISTORY

NAME: DATE:

Yes	No		Yes	No	
☐	☐	Asthma _____	☐	☐	Head or Spinal injuries _____
☐	☐	Kidney Disease _____	☐	☐	Seizures, Convulsions, or Fainting _____
☐	☐	Tuberculosis _____	☐	☐	Extensive Confinement by Illness or Injury _____
☐	☐	Diabetes _____	☐	☐	Temporal Arteritis _____
☐	☐	Migraines _____	☐	☐	Carotid Artery Disease _____
☐	☐	Psychiatric Disorder _____	☐	☐	Stroke _____
☐	☐	Nervous Disorder _____	☐	☐	High Blood Pressure _____
☐	☐	Heart Disease _____	☐	☐	HIV _____
☐	☐	Ulcer _____	☐	☐	Liver Disease _____
☐	☐	Multiple Sclerosis _____	☐	☐	Rheumatoid Arthritis _____
☐	☐	Sickle Cell Anemia _____	☐	☐	Cancer _____
☐	☐	Do you smoke? _____	☐	☐	Other Diagnosed Health Problems _____
☐	☐	Taken illegal substances within the last 12 months?	☐	☐	Do you Drink? _____

Please list all Medications you are **currently taking**:

Please list all Medications you are **allergic** to:

SURGICAL HISTORY (PLEASE INCLUDE DATE & TYPE)

PATIENT INFORMATION

DEMOGRAPHICS

NAME LAST FIRST MI			DATE:
STREET ADDRESS			SOCIAL SECURITY #
CITY	STATE	COUNTY	ZIP CODE
HOME PHONE	WORK PHONE	BIRTHDATE	SEX
SPOUSE	WORK PHONE		MARITAL STATUS ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED
EMPLOYER NAME	POSITION		EMAIL ADDRESS
EMERGENCY CONTACT		EMERGENCY PHONE	
PRIMARY CARE PHYSICIAN			

BILLING

GUARANTOR (FINANCIALLY RESPONSIBLE PERSON) LAST FIRST MI				RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER
STREET ADDRESS				SOCIAL SECURITY #
CITY	STATE	COUNTY		ZIP CODE
HOME PHONE	WORK PHONE			
PRIMARY INSURANCE	POLICY HOLDER	POLICY ID #	SSN #	INSURED'S BIRTHDATE
SECONDARY INSURANCE	POLICY HOLDER	POLICY ID #	SSN #	INSURED'S BIRTHDATE
SEND WORKERS COMPENSATION TO:		AUTHORIZED BY		DATE OF INCIDENT:

THE EYE CENTER of Parkville

Nicole D. Verachtert, O.D. *Stephanie A. Staatz, O.D.*

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her judgment.

Medicare Authorization

I request payment of authorized Medicare benefits be made on my behalf to The Eye Center of Parkville, for any services furnished to me by that physician/supplier. I authorize the holder of medical information, about me, to release to Medicare and its agents any information needed to determine these benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer to the agency shown. I Medicare assigned cases, the physician or supplier agrees to accept the chare determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization

The following is to be filled out if you have a Medigap insurance policy for which you wish to assign benefits. A Medigap or Medicare Supplemental policy is a health insurance policy or other health plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer or employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.

This agreement is in effect until revoked in writing by the patient.

Notice of Privacy Practices

I have been given a copy of the Notice of Privacy Practices of The Eye Center of Parkville to review.

Signature:_____ **Date:**_____

THE EYE CENTER of Parkville

Nicole D. Verachtert, O.D. *Stephanie A. Staatz, O.D.*

Optomap Ultra-Widefield Retinal Image

The Optomap is state of the art technology that represents the latest in eye disease detection. It allows us to more thoroughly evaluate your retina, the sensitive tissue in your eye that is responsible for vision. The retina is susceptible to a variety of diseases, which can lead to vision loss. Early detection of retinal abnormalities is crucial to protect your vision. The image is kept as a part of your record and we can compare the pictures year after year at your annual examinaiton.

Drs. Staatz and Verachtert highly recommend the Optomap Retinal Image, for evaluation and documentation, be performed in addition to your routine examination.

-Everyone, including children, should have baseline photos
-No dilation is necessary to perform this test
-The doctors immediately analyze and review the test with you
-Retinal images are stored for future references and comparison
-You should be tested annually if you have:

*Diabetes	*Retinal Problems
*Glaucoma	*Macular Degeneration
*Hypertension	*High Myopia

This procedure is not covered by basic vision insurance. The fee for the Optomap Retinal Imageis 39.00.

I have read the information about Retinal Photography.

☐ Yes, I choose to have retinal photography performed at this time.

☐ No, I choose to defer the test at this time.

Signature _____ Date _____

Parkville Commons - 6325 Lewis St., Suite 114 - Parkville, MO - 64152 - 816.505.0100 - fac 816.505.2301
www.theeyecenterofparkville.com