David A. Kingrey, M.D.
Jeffrey A. Boomer, M.D.
Lucas T. Lenci, M.D.
Bruce B. Ochsner, M.D.

Updated:	Office Use Only
____________________	Date: __________
____________________	Date: __________

Vision Surgery Consultants
1100 North Topeka • Wichita, Kansas 67214
(316) 263-6273 • 1-800-262-0118

218 S. Kansas Ave. • Newton, KS 67114
(316) 283-1400 • 1-800-870-0067

Surgery Center:
Associated Eye Surgical Center, LLC
1100 North Topeka • Wichita, Kansas 67214
(316) 263-6273 • 1-800-262-0118

Please complete all sides of form. We will need to copy your insurance cards and picture identification.

❊ ❊ ❊ ❊ ❊ ❊ ❊ ❊ ❊ ❊ Please bring this form with you on the day of your appointment. ❊ ❊ ❊ ❊ ❊ ❊ ❊ ❊ ❊ ❊

PATIENT INFORMATION - **Please Print all information in Ink. Please do not use white out.**

Do Not mail this form back!

Date ______________________________

Legal Name ______________________________
First M. Init. Last

Preferred Name ______________________________

Address ______________________________

____
City State Zip

Primary Phone ______________________________
please include area code

Secondary Phone ______________________________
please include area code

E-mail: ______________________________

Sex: M ___ F ___ Age _____ Birth date ____________

Marital Status ______________________________

Patient SS# ______________________________

Occupation ______________________________

Employer ______________________________

Employer Address ______________________________

Work Phone # ______________________________

INSURANCE

Primary Insurance ______________________________

Secondary Insurance ______________________________

Subscriber Name: ______________________________
if different than patient

Relationship to patient: ______________________________

Birth date: ______________ SS# ______________

Pharmacy: ______________________________

____
address phone

Referred by: ______________________________

Currently a resident in skilled nursing home? Yes ___ No ___

Name of nursing home: ______________________________

❊ ❊

Primary Care Doctor's Name: ______________________________ Date last seen ______________

Address: ______________________________

(over)

❊ ❊

AUTHORIZATION OF TREATMENT: I authorize my physicians Dr. Kingrey, Dr. Boomer, Dr. Lenci and/or Dr. Ochsner to examine, diagnose and treat any eye related illness I may have.

AUTHORIZATION TO RELEASE INFORMATION: I authorize Dr. Kingrey, Dr. Boomer, Dr. Lenci and/or Dr. Ochsner to disclose information regarding my illness to my Physician, Optometrist, Medical Facility, or my Insurance Company. A photostat copy of this authorization will be considered valid.

CONTACT RELEASE INFORMATION: I authorize/permit Vision Surgery Consultants ie: Dr. Kingrey, Dr. Boomer, Dr. Lenci and/or Dr. Ochsner and their business associates to contact me, and all other responsible parties on my account, on our cell phone or other mobile devices concerning any and all aspects of my account.

ASSIGNMENT OF BENEFITS: I assign and authorize for direct payment of medical benefits otherwise payable to me by my insurance to: Vision Surgery Consultants, P.A. I understand that I am financially responsible for charges not covered by my insurance. If incorrect or wrong insurance is supplied to this office, or if I have AN HMO INSURANCE AND DO NOT HAVE PRIOR APPROVAL IN WRITING BY MY PRIMARY CARE PHYSICIAN TO BE SEEN, then I agree to pay for all charges if examined.

Signature: X____ Date ___________________________________

❊ ❊

EYE HEALTH HISTORY

Optometrist's Name ____ Date of last eye exam_______________________

Address: ____

Do you wear glasses? Yes ____ No ____ All the time ____ Occasionally ____

When: Reading ____ Driving ____ Television ____ Other ____ What is the age of your current pair of glasses? ____

Do you wear contacts? Yes ____ No ____ Hard ____ Gas permeable ____ Soft ____ Astigmatism ____ Hrs/Days ____

Describe any problems you may have with your contacts or glasses; ____

____

What eye problems are you presently experiencing? ____

____

Mark the "Yes" or "No" to indicate if you have or have had any of the following.

Blindness	Yes ____	No ____	Glaucoma	Yes ____	No ____
Blurred Vision - Distance / Near	Yes ____	No ____	Headaches	Yes ____	No ____
Burning Eyes	Yes ____	No ____	Itching Eyes	Yes ____	No ____
Cataracts	Yes ____	No ____	Lazy Eye	Yes ____	No ____
Color Vision, Poor	Yes ____	No ____	Light Sensitive	Yes ____	No ____
Crossed Eyes	Yes ____	No ____	Migraine Headaches	Yes ____	No ____
Decreased Vision	Yes ____	No ____	Night Vision, Poor	Yes ____	No ____
Discharge from Eyes	Yes ____	No ____	Retinal Disease	Yes ____	No ____
Dizzy Spells	Yes ____	No ____	Seeing Flashes of Light	Yes ____	No ____
Dry Eyes	Yes ____	No ____	Temporary Loss of Vision	Yes ____	No ____
Eye Infection	Yes ____	No ____	Turned Eyes	Yes ____	No ____
Eye Injury	Yes ____	No ____	Twitching Eyelid	Yes ____	No ____
Eye Strain	Yes ____	No ____	Vision Poor	Yes ____	No ____
Fainting Spells, Blackouts	Yes ____	No ____	Watering Eyes	Yes ____	No ____
Floaters or Spots	Yes ____	No ____			

❊ ❊

PATIENT'S NAME _____ **HT**_____ **WT**_____ SEX _____ AGE _____

HEALTH HISTORY: **DURABLE POWER OF ATTORNEY** ❒ **Yes** ❒ **No**

ADVANCED DIRECTIVE (Living Will) ❒ **Yes** ❒ **No** **If yes, you may provide a copy.**

HISTORY OF DISEASE — Are you being treated for or have you had any of the following?: **PLEASE CIRCLE Y or N**

LUNG
Emphysema / COPD Y N
Asthma .....Y N
Chronic or A.M. Cough.....Y N
Recent "Cold" .....Y N
Shortness of Breath.....Y N
Sleep apnea / CPAP .....Y N
Blood clots /
Pulmonary Embolism ..... Y N
Wearing Oxygen.....Y N
How Much _____

VASCULAR
High Blood Pressure Y N
Heart Disease/Heart Attack Y N
Yr. ____
Chest Pain/Angina Y N
Last Experienced_____

Coronary Stent .....Y N
When _____
Congestive Heart Failure .....Y N
Palpitations/Irreg/A-Fib.....Y N
Pacemaker / AICD .....Y N
Stroke / TIA .....Y N
Bleeding Disorder/Sickle Cell..Y N
High Cholesterol .....Y N

SYSTEMIC - PLEASE CIRCLE
Diabetes .....Y N
Insulin / NonInsulin / Diet
Type 1 or Type 2 _____
Thyroid Condition .....Y N
Jaundice .....Y N
Kidney / Bladder .....Y N
Dialysis .....Y N

Reflux / Bowel Disease .....Y N
Hepatitis B,C.....Y N
HIV Positive .....Y N
Fainting / Dizziness .....Y N
Tremors / Parkinson's.....Y N
Seizures / Epilepsy .....Y N
Neuromuscular Disease. ....Y N
Restless Leg Syndrome .....Y N
Cancer -Type _____Y N
Date_____
Autoimmune Disease .....Y N
Type_____
Dementia / Alzheimer's.....Y N
Arthritis .....Y N
Back / Neck Problems .....Y N
Are you pregnant now? .....Y N

Depression / Anxiety.....Y N
Blood thinner .....Y N
Shingles.....Y N
When_____
Where_____
Hard of Hearing/Hearing Aid.Y N
Physical Limitations .....Y N
Explain_____
Have you ever had MRSA? Y N
When_____
Where_____
Other serious medical conditions?
_____
_____
_____

1. Do you have dentures, loose teeth, capped, or broken or missing teeth? Y N If yes, please circle which apply.
2. Have you ever had anesthesia? Y N Please indicate: Local ___ Regional ___ General ___
   Any complication? Y N Please Explain _____
3. Family history of anesthesia complications? Y N Please Explain _____
4. Have you ever taken medication for an enlarged prostate? Y N Medication name?_____
5. **SOCIAL HISTORY:** Tobacco use / smoking Y N How much?_____ Have you quit? Y N How long ago?_____.
   Alcohol use Y N Amt per day or week _____ Illegal drug use? Y N
6. **FAMILY HISTORY:** Has any member of your family had these diseases (circle all that apply): Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis. Other heritable disease _____
7. **SURGICAL HISTORY:**
   Previous Eye Surgery Y N Please List _____
   Other Surgeries Y N Please List _____
8. **ALLERGIC TO ANY MEDICATIONS? Y N** If yes, list medication and reaction below.

Allergies:	Reaction:	Allergies:	Reaction:

9. **ARE YOU ALLERGIC TO LATEX? Y N** If yes, describe reaction _____

Routine pre-op tests are not required for eye surgery under regional anesthesia, and a preoperative examination by your family physician is not required. Persons benefit by seeing their MD or DO once a year or before eye surgery, and we would encourage you to do so.

Patient's Signature

FOR OFFICE USE ONLY

Patient #	INTERVIEWER'S SIGNATURE	TODAY'S DATE

Complete back side →

10. PLEASE LIST ALL MEDICATIONS
Prescriptions, Over-the-Counter, and ALL eye drops.

Medication	Dosage	How Often	How Taken (oral, drops, injections, etc.)

ADD ADDITIONAL PAGE IF NEEDED TO LIST ALL MEDICATIONS.

Kingrey / Boomer / Lenci / Ochsner Signature ____________ Date ________

FOR OFFICE USE:

Date: Are you diabetic? Y or N Pt. Initial ________ Tech. Initial ________ M.D. Initial ________	Date: Are you diabetic? Y or N Pt. Initial ________ Tech. Initial ________ M.D. Initial ________
Date: Are you diabetic? Y or N Pt. Initial ________ Tech. Initial ________ M.D. Initial ________	Date: Are you diabetic? Y or N Pt. Initial ________ Tech. Initial ________ M.D. Initial ________
Date: Are you diabetic? Y or N Pt. Initial ________ Tech. Initial ________ M.D. Initial ________	Date: Are you diabetic? Y or N Pt. Initial ________ Tech. Initial ________ M.D. Initial ________