David A. Kingrey, M.D.
Jeffrey A. Boomer, 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 ___________

Have you ever visited our office under another name?
(divorce, marriage, adoption, etc.) Yes ___ No ___

If yes, what name? ______________________

Marital Status: ❒ Married ❒ Single

Patient SS# ______________________

Patient's Occupation ______________________

Employer ______________________

Employer Address ______________________

Work Phone # ______________________

INSURANCE

Primary Insurance ______________________

Secondary Insurance ______________________

Subscriber Name: ______________________
if different than patient

Relationship to patient: ______________________

Birth date: ____________ SS# ______________
if different than patient

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

Name of nursing home: ______________________

____

Referred by: ❒ Doctor ❒ Friend ❒ Internet ❒ Relative ❒ Other

Referral Name: ______________________

(over)

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

AUTHORIZATION TO RELEASE INFORMATION: I authorize Dr. Kingrey and/or Dr. Boomer 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 and/or Dr. Boomer 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 ______________________________

Pharmacy: ____

Address:____ Phone: ____________________

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

Address: ____

EYE HEALTH HISTORY

Optometrist's Name ________________________________ Date of last eye exam________________

Address: ____

Do you wear glasses? Yes ____ No ____ All the time ____ Reading ____ Driving ____

What is the age of your current pair of glasses? __________

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

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

____

What eye problems are you presently experiencing?______________________________________

____

____

____

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
- 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
- Year ______
- 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 - Date __________Y N
- Type____________________
- 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________________
- Had MRSA?..................... Y N
- When____________________
- Where____________________
- Other serious medical conditions?
- ____________________________
- ____________________________
- ____________________________
- ____________________________

1. Do you have dentures, partial, bridge, loose teeth, capped, 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.

I agree by signing this form that all above information is correct.

____
Patient's Signature

FOR OFFICE USE ONLY

Patient #	INTERVIEWER'S SIGNATURE	TODAY'S DATE

10. PLEASE LIST ALL MEDICATIONS

I am in good general health and take NO 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 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 ________