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 _____
if different than patient

Subscriber Name: _____
if different than patient

Relationship to patient: _____

Birth date: _____ SS# _____

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

Name of nursing home: _____

_____

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

Referral Name: _____

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

AUTHORIZATION TO RELEASE INFORMATION: I authorize Dr. Kingrey, Dr. Boomer, and/or Dr. John 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, and/or Dr. John 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 _____

PATIENT'S NAME _____ HEIGHT _____ WEIGHT _____ SEX ___ AGE ____

Pharmacy: _____

Address: _____ Phone: _____

Primary Care Doctor's Name: _____ Date last seen _____

Address: _____

DURABLE POWER OF ATTORNEY ❒ **YES** ❒ **NO**

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

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 _____

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

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.....Y N
Date & 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_____

Please list other serious medical conditions
_____
_____

Have you ever taken medication for an enlarged prostate? ❒ Y ❒ N Medication name?_____

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

FAMILY HISTORY:

Has any member of your family had these diseases? ❒ Blindness ❒ Cataract ❒ Glaucoma ❒ Diabetes ❒ Hypertension
❒ Heart Disease ❒ Stroke ❒ Cancer ❒ Thyroid Disease ❒ Arthritis. ❒ Other heritable disease _____

SURGICAL HISTORY:

Previous Eye Surgery ❒ Y ❒ N Please List _____
Other Surgeries ❒ Y ❒ N Please List _____

ALLERGIC TO ANY MEDICATIONS? ❒ **Y** ❒ **N** If yes, list medication and reaction below.

Allergies:	Reaction:	Allergies:	Reaction:

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

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.)