Please complete the form below and bring it with you to your appointment.

EYE CARE *Specialists*, L.L.C.

PATIENT INFORMATION

PATIENT'S FULL NAME _____

Social Security# _____ Birth Date _____ Sex: ☐ Male ☐ Female

Address _____ City/State _____ Zip _____

Home Phone _____ Work _____ Cell _____

Other Contact (Friend/Neighbor/etc.) _____ Phone _____

Who should be notified in an Emergency? _____

Relationship to patient _____ Phone _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse Name _____

Work/School Status: ☐ Employed ☐ Retired ☐ F/T Student ☐ P/T Student ☐ N/A

Occupation _____

Employer / School Name _____

Employer / School Address _____

If patient is a minor/child, please list Parent/Legal Guardian

Father _____ Social Security # _____

Address _____

Employer _____ Occupation _____ Phone _____

Mother _____ Social Security # _____

Address _____

Employer _____ Occupation _____ Phone _____

PRIMARY INSURANCE PLAN _____ Effective Date _____

Policy / Patient ID _____ Group IL (if any) _____

SECONDARY INSURANCE PLAN _____ Effective Date _____

Policy / Patient ID _____ Group IL (if any) _____

If any insurance policy is in the name of an individual other than the patient's name (i.e. spouse, parent, etc.) please provide the following information:

Name _____ Birth Date _____

Address _____

Relationship to Patient _____ Phone _____

Social Security# _____ If patient is a minor, who is responsible for payment? _____

Who referred you to see us? _____

Have other members of your family been seen by us? ☐ Yes _____ ☐ No

Patient Signature (or Legal Guardian) _____ Date _____ PRINT

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LASIK Treatment Patient History

PATIENT INFORMATION

Name:		Date of Birth:		Today's Date:	

Who is your regular optometrist *(if you do not have a regular doctor, who have you seen for glasses and contacts within the last two years)*

Dr. _____ Date of Last Eye Exam: _____

BRIEF MEDICAL HISTORY

Do you have any current health conditions? *(Arthritis, Diabetes, High Blood Pressure, Autoimmune Disease, Scarring Keloid, Pregnancy, AIDS/HIV, Herpes, Shingles)*

☐ NO ☐ YES If YES, please list:

Is there a family history of Keratoconus or corneal transplant?

☐ NO ☐ YES If YES, please list:

Are you currently taking any medications?

☐ NO ☐ YES If YES, please list:

Are you allergic to any medications?

☐ NO ☐ YES If YES, please list:

Have you had any previous eye conditions, injuries or surgery?

☐ NO ☐ YES If YES, please list:

Has anyone else in your family had a surgical (RK) or laser (LASIK) procedure for vision correction?

☐ NO ☐ YES If YES, please list:

VISION HISTORY

Which do you primarily depend on for vision correction: ☐ Contacts ☐ Glasses

If glasses, have you worn contacts in the past? ☐ YES ☐ NO

If YES, why do you no longer wear contacts?

If contacts, how many years have you worn contacts? _____

Please indicate which type of contact lenses you currently wear now? *(or have worn in the past)*

☐ Soft Daily Wear ☐ Soft Extended Wear ☐ Rigid Gas Permeable ☐ Hard Lenses ☐ Soft Toric Lenses ☐ Disposable

Please rate your level of satisfaction with your current glasses or contacts:

☐ Perfect ☐ Good ☐ Fair ☐ Poor ☐ Failure

Please check reasons for your problems with glasses or contacts:

☐ Poor Comfort ☐ Dependence ☐ Occupational Limitations ☐ Poor cosmetic appearance

☐ Safety / Security ☐ Nuisance ☐ Tired of having poor vision ☐ Restricts Physical Activities

☐ Limits enjoyment of certain activities ☐ Other problems (describe):

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EYE CARE *Specialists*, L.L.C.
360 S. Mt. Auburn Rd. • P.O. Box 2018 • Cape Girardeau, MO 63702-2018

SIGNATURE ON FILE FOR PRIVATE INSURANCE

Please complete the following for our files in the event our physicians see you in the future for services covered by insurance.

Name of Patient: _____ **ID #** _____

Name of Private Insurer: _____ **Group #** _____

I request payment of authorized Private Insurance benefits be made to this provider and also authorize any holder of medical information about me to release to the above named Private Insurance insurer any information needed to determine benefits payable for services from EYE CARE *Specialists*, LLC.

_____ _____

Signature of Patient or Legal Guardian ***Date Signed***

PRINT

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EYE CARE *Specialists*, L.L.C.

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____
Patient's Signature (or Representative)

Relationship to Patient (if other than patient):_____

Date:_____

In front of _____
Printed name – Practice representative

PRINT