Keller Eye Care, LLC

Welcome To Our Office

First Name ______ MI ______ Last Name ______ Preferred Name ______ ☐Male ☐Female

Street Address ______ City ______ State ______ Zip ______

Date of Birth ______ Social Security Number ____-____-____ Race ______ Language Preference ______

Preferred Phone # ______ Home/Work/Cell

Alternate Phone # ______ Home/Work/Cell

Email Address* ______ How did you hear about our office? ______

*By providing your e-mail address, you are authorizing us to communicate with you by e-mail. We must remind you that e-mail communications, particularly those over the internet, are inherently unsecure. So, we cannot assure the confidentiality of information communicated by e-mail.

What is the best way for us to contact you? ☐Home ☐Cell ☐Work ☐Email

Emergency Contact: Name ______ Phone Number ______

PRIMARY MEDICAL INSURANCE INFORMATION (Please fill out below)

Name of Insurance Company ______ Primary Insured's Name ______ ☐M ☐F

Insured's I.D. Number ______ Group Number ______ Insured's DOB ______

Patient Relationship to Insured

☐Self ☐Spouse ☐Child ☐Other

Patient Status ☐Single ☐Married ☐Other

☐Employed ☐Full-Time Student ☐Part-Time Student ☐Other

SECONDARY MEDICAL INSURANCE INFORMATION

Name of Insurance Company ______ Primary Insured's Name ______ ☐M ☐F

Insured's I.D. Number ______ Group Number ______ Insured's DOB ______

Patient Relationship to Insured

☐Self ☐Spouse ☐Child ☐Other

Patient Status ☐Single ☐Married ☐Other

☐Employed ☐Full-Time Student ☐Part-Time Student ☐Other

PRIMARY VISION INSURANCE INFORMATION

Name of Insurance Company ______ Primary Insured's Name ______ ☐M ☐F

Insured's I.D. Number ______ Insured's Social Security Number ______ Insured's DOB ______

PATIENT HISTORY AND INFORMATION

____

Primary Care/Referring Physician and Clinic Name   Phone Number

What is the main reason for today's exam? ____________________

YOUR MEDICAL HISTORY **Please circle any conditions you have or mark NONE if applicable.**

				NONE
Constitutional	Cancer *Type of cancer:* ____________	*Fatigue Syndrome*	Development Disabilities	
Neurological	Cerebral Palsy *Epilepsy*	*Migraine* Other:	Multiple Sclerosis	
Psychiatric	Bipolar Disorder *Attention Deficit*	*Anxiety Disorder* Other:	Depression	
Cardiovascular	Stroke *High Blood Pressure*	*Vascular Disease* Heart Disease	Congestive Heart Failure *Other:*	
Respiratory	COPD *Bronchitis*	*Asthma* Sleep Apnea	Emphysema *Other:*	
Kidney/Bladder	STD *Other:*	*Kidney Disease*	Prostate Disease	
Females Only	Are you pregnant?	*Nursing?*		
Muscle, Bones, Joints	Fibromyalgia *Muscular Dystrophy*	*Gout* Ankylosing Spondylitis	Arthritis *Other:*	
Endocrine	Diabetes	*Thyroid Dysfunction*	Other:	
Blood/Lymph	High Cholesterol *HIV/AIDS*	*Anemia* *Hepatitis*	Leukemia	
Allergy/Immunologic	Rheumatoid Arthritis *Drug Allergies*	*Sjogren's Syndrome* Environmental Allergies	Lupus *Other:*	

Please print clearly Current

Medications: ____________________

____

Current Eye Drops: ____________________

Do you have any allergies to medications? **YES NO** If YES, list the meds: ____________________

Do you have a latex allergy? YES NO

YOUR EYE HISTORY Please check any eye conditions you have had or currently have.

☐Dry Eye
☐Inflammatory Disorder
☐Cataract
☐Nystagmus
☐Strabismus (Eye Turn)
☐Macular Degeneration
☐Amblyopia (Lazy Eye)
☐Keratoconus
☐Glaucoma Suspect
☐Surgery____________
☐Retinal Detachment
☐Other____________
☐Retinal Hole
☐ Injury____________
☐ Glaucoma
☐ Eye patching
☐ Retinal Degeneration

Do you drink alcohol? ☐None ☐Occasional ☐1 Per Day ☐2-3/day ☐4+/day

Do you smoke? ☐None ☐Occasional ☐1/2 pack/day ☐1 pack/day ☐1+pack/day

Have you ever been a regular smoker? YES NO

FAMILY HISTORY **Please list immediate family members (Mother, Father, Grandparent, Sibling) who have or have had any of the following:**

Thyroid Disease	Lazy Eye	Glaucoma
High Blood Pressure	Dry Eye	Severe Far-sighted
Diabetes	Glaucoma Suspect	Cataract
Cancer	Eye Turn	Severe Near-sighted
Macular Degeneration	Nystagmus	Retinal Detachment
Other		

YOUR SOCIAL HISTORY

Current Occupation________________________________ Employer______________________________

SPECTACLE LENS HISTORY

Do you currently wear glasses? YES NO If no, have you ever worn glasses? YES NO

Glasses Owned ☐Single Vision ☐Bifocals ☐Trifocals ☐Progressive ☐Back-up ☐Safety ☐Sports

Have you had trouble in the past with glasses? YES NO ________________________________

CONTACT LENS HISTORY

Have you ever tried contact lenses? YES NO Reason for stopping___________________________

Do you currently wear contact lenses? YES NO

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Keller Eye Care make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

☐ I have read or had explained to me Keller Eye Care's Notice of Privacy Practice and AGREE to continue my care with Keller Eye Care under said terms.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received:

Name: ____________________________ Relationship:__________________

Name: ____________________________ Relationship:__________________

________________________________ ________________________________

Signature of Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

________________________________ ________________________________

Representative Relationship to Patient

Keller Eye Care, L.L.C.
Medical/Vision Services Financial & Office Policies

I hereby authorize and consent to Vision/Medical treatment by Jarrod R. Keller, OD for myself or my dependent. I authorize Keller Eye Care, L.L.C. to release my (or my dependent's) medical or vision information to my (or my dependent's) Family Physician or to my (or my dependent's) insurance company, if requested. This allows Keller Eye Care to provide coordinated patient health care and optimal insurance coverage.

I authorize Keller Eye Care to request prior treatment records from
______________________________ to aid in my total ocular care/treatment.

Signed:______________________________

I understand that I am financially responsible for payment for all medical/vision treatment rendered to me (or my dependent) by Keller Eye Care. Payment is required in full if there is no insurance coverage. **You will be responsible for any portion of your bill not paid for by your (or your dependent's) insurance company.** For instance, during the yearly comprehensive examination, refraction will be performed in order to determine the best corrective lenses to be prescribed. Refraction (Billing code 92015) is considered to be "non-covered" or "not medically necessary" service by most insurance company standards, and will be transferred to the responsibility of the patient.

I understand that Keller Eye Care, as a courtesy to me, will submit a claim to my (or my dependent's) insurance carrier, and I authorize payment directly to Keller Eye Care for the benefits otherwise payable to myself (or my dependent) under the terms of this contract. It is my responsibility to maintain current coverage information in order to meet filing deadlines and for the payment of any remaining balance after the payment of my (or my dependent's) insurance carrier.

I understand that under the Keller Eye Care office policy, patients are required to give at least a 24 hour notice if a scheduled appointment needs to be cancelled or rescheduled. Failure to comply with these guidelines regarding appointments will result in a **Broken/No-show appointment charge**.

By signing below, you are acknowledging that you have read the statements above, and have agreed to comply with the Financial and Office Policies at Keller Eye Care, L.L.C.

Patient Name:______________________________ Date of Birth:______________

Patient/Guardian Signature______________________________ Date:______________