KRATES EYE CENTERS

Welcome to our office.

Name: _____ Date of Birth: _____

Address: _____ SSN (optional): _____

City/State/Zip: _____ Telephone: _____

E-mail: _____ Cell Telephone: _____

Please circle one Preferred Method of Contact: Home Phone Cell Phone E-mail Regular Mail

Spouse's Name: _____ Spouse's Date of Birth: _____

Name of person responsible for this account: _____

Address: _____ Telephone Number: _____

Date of Birth: _____ Relationship to Patient: _____

Primary Insurance: _____

Secondary Insurance: _____

Is this visit Work Related: _____

Family Physician Name & Telephone No: _____

Who referred you to our office: _____

Emergency Contact Person_____Telephone_____

ON MY BEHALF, YOU MAY RELEASE MY MEDICAL CARE INFORMATION TO:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I acknowledge that Krates Eye Centers follows the HIPPA Privacy Policies. A copy of the notice is available from the receptionist. I authorize the release of any private information concerning my health care, advice and treatment provided for the purpose of evaluating and administering care and/or claims of insurance and government issued benefits. I also hereby authorized payment of insurance benefits otherwise payable to me, directly to the doctor. Our practice is committed to providing you with the best possible treatment. Copay is expected at the time of visit. Krates Eye Centers participates with most major insurance plans. We follow the rules and guidelines of insurance plans. We will file a claim with your insurance company for payment for services rendered. It is the patient's responsibility to know their coverage. The patient is responsible for deductibles, copays, coinsurance and/or anything deemed patient responsibility by your insurance company.

Signed: _____ Date: _____

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: ____/____/____

Primary Care Physician: _____

Referring /Specialty Dr._____

Pharmacy: _____

Pharmacy Location (street & city) _____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ French □ Italian □ Japanese □ Portuguese □ Russian
□ Spanish

Allergies: Reaction Severity

_____ mild / moderate / severe

_____ mild / moderate / severe

Past Ocular History: (Please mark all that apply)

□ Overall Healthy
□ Amblyopia (Lazy eye)
□ Aphakia
□ Astigmatism
□ Myopia (Near sighted)
□ Cataracts
□ Diabetic Retinopathy
□ Dry Eyes
□ Glaucoma
□ Optic Neuritis
□ Hyperopia (Far sighted)
□ Iritis
□ Keratoconus
□ Macular Degeneration
□ Retinal Detachment

Other_____

Ocular Surgeries: (Please mark all that apply)

□ No prior ocular surgery
□ Blepharoplasty (Eyelid surgery)
□ Cataract Surgery
□ Corneal Transplant
□ Foreign Body Removal
□ Retinal Laser Surgery
□ LASIK
□ PRK
□ Punctal Plugs
□ RK
□ Strabismus Surgery
□ Trabeculectomy (Glaucoma surgery)
□ Eye Muscle Surgery
□ Vitrectomy

Other_____

Ocular Significant Illnesses: (Please mark all that apply)

□ Overall Healthy
□ AIDS
□ Diabetes
□ Rheumatoid Arthritis
□ Herpes
□ HIV Positive
□ Hypertension
□ Hypothyroidism
□ Lupus
□ Multiple Sclerosis
□ Sjogren's Disease
□ Graves' Disease
□ Hyperthyroidism

Other_____

Current Eye Medications: (Please list)

_____

_____

_____

Systemic Illnesses:

- □ No history of illnesses
- □ Anemia
- □ Arthritis
- □ Arrhythmia
- □ Asthma
- □ Bleeding Disorder
- □ Cancer
- □ Thyroid Disease
- □ Congestive Heart Failure
- □ COPD
- □ Diabetes
- □ Eczema
- □ Fibromyalgia
- □ Headache
- □ Hearing Loss
- □ Hepatitis
- □ High Blood Pressure
- □ High Cholesterol
- □ HIV
- □ Kidney Disease
- □ Kidney Stones
- □ Liver Disease
- □ Lung Disease
- □ Lupus
- □ Migraine
- □ Polymyalgia
- □ Psychiatric Disorder
- □ Skin Cancer
- □ Stroke

Other_____

General Surgeries / Operations:

_____

_____

_____

Current Other Medications (Pills, Inhalers, Injections):

NAME	STRENGTH (% or mg)	HOW OFTEN

Family History: M=mother, F=father, B=brother, S=sister, GM=grandmother, GF=grandfather

- □ Arthritis _____
- □ Stroke _____
- □ Lazy Eye _____
- □ Heart Disease _____
- □ High Blood Pressure _____
- □ Diabetes _____
- □ Blindness _____
- □ TB _____
- □ Macular Degeneration _____
- □ Retinal Disease _____
- □ Kidney Disease _____
- □ Glaucoma _____
- □ Cancer _____
- □ Cataracts _____

Other_____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ Yes □ No *If yes how much and how often?* _____

Drug Use: □ Yes □ No *If yes what and how often?* _____

This information is required in order for our office to be in compliance with the new Federal Health and Information Guidelines effective January 2014.

OFFICE USE ONLY: PRIMARY CARDIOLOGIST PULMONOLOGIST EKG

KRATES FARLEY KATSOULAKIS LUKE BEYER