KRATES EYE CENTERS

Last Name _____First Name _____ Middle: _____

Social Security Number_____Date of Birth _____ Sex: □ M □ F

Street Address _____ City,State, Zip Code_____

Spouse's Name _____ Spouse's Date of Birth_____

Home Phone _____ Cell Phone (required)_____

Email Address (required) _____

Reminder Preference (CIRCLE): **HOME** **CELL (CALL)** **CELL (TEXT)** **EMAIL**

Please note that our patient statements have gone digital. You must have an email on file with our office.

INSURANCE INFORMATION (Please present your cards at the front desk for scanning.)

Name of person responsible for this account _____

Relationship to Patient (can be self) _____ Date of Birth of Responsible_____(required)

Address if different from above:_____

Primary Medical Insurance _____ Secondary (*if applicable*)_____

Policy ID_____ Policy ID_____

Group ID_____ Group ID_____

Is this visit work related? _____ If yes, please fill out the additional forms provided by the front desk staff

Emergency Contact _____Phone_____ Relationship_____

List below any persons we can release your medical information to, such as spouse, children, siblings, or relatives.

Name _____Relationship to patient_____Phone_____

Name _____Relationship to patient_____Phone_____

I acknowledge that Krates Eye Centers follows the HIPAA Privacy Policies. A copy of the notice is available from the front desk. I authorize the release of any privacy 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 insurance plans. We follow the rules and guidelines of insurance plans. We will file a claim with your insurance company for payment of services rendered. It is the patient's responsibility to know their coverage. The patient is responsible for deductibles, coinsurance and/or anything deemed patient responsibility by your insurance company.

Signed: _____ Date: _____

MEDICAL HISTORY QUESTIONNAIRE

Name _____Date of Birth: _____

Primary Care Physician _____Phone: _____

Referring/Specialty Physician _____Phone:_____

Cardiologist Name (if applicable):_____Phone:_____

Pharmacy _____ Location _____

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

Ethnicity: □ Hispanic □ Non Hispanic

Preferred Language: □ English □ Spanish □ Greek □ Italian □ Japanese □ Polish □ Other_____

Allergies	**Reaction**	**Severity**
_____		mild / moderate / severe
_____		mild / moderate / severe

Past Ocular History (*Please mark all that apply*)

□ Cataracts	□ Diabetic Retinopathy	□ Dry Eye	□ Glaucoma	□ Macular Degeneration
□ Keratoconus	□ Myopia (near sight)	□ Optic Neuritis	□ Iritis	□ Amblyopia (lazy eye)
□ Retinal Detachment	□ Hyperopia	□ Hypothyroidism	□ Lupus	□ Diabetes
□ Hypertension	□ Multiple Sclerosis	□ Hyperthyroidism	□ Graves' Disease	
□ Rheumatoid Arthritis	□ Sjögren's Disease			

Other, if not listed above _____

Ocular Surgeries (*Please mark all that apply*)

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

Other, if not listed above _____

Current Eye Medications (*if applicable*)

_____

_____

Systemic Illnesses

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

□ Cancer □ Hearing Loss □ Liver Disease □ Stroke
□ Thyroid Disease

Other, if not listed above _____

General Surgeries / Operations: (*Please list*)

_____

_____

_____

Current Systemic Medications, please include all pills, inhalers, or injections.

Name Strength (% or mg) How Often

_____

_____

_____

_____

_____

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

□ Arthritis _____ □ Diabetes _____ □ Kidney Disease _____ □ TB _____

□ Stroke _____ □ Blindness _____ □ Glaucoma _____ □ Lazy Eye _____

□ Cancer _____ □ Heart Disease _____ □ Macular Degeneration _____

□ Cataracts _____ □ High Blood Pressure _____ □ Retinal Disease _____

Other, if not listed _____

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, how much 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 OF 2014.