

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____ Social Security #: _____

Sex: Male Female Marital Status: Married Single Divorced Widowed

Race: African American Asian Pacific Caucasian Hispanic Native American Other: _____

Occupation: _____ Employer: _____

Employer's Address: _____

Emergency Contact Name: _____ Phone #: _____

MEDICAL INFORMATION

List all allergies to medication/latex/adhesives: _____

Primary Care Physician Name _____ Address _____ Phone # _____

Date of Last Eye Exam _____ Name of Previous Eye Care Provider _____

Diabetes/Year diagnosed _____ Insulin Oral Medication _____ Diet-Controlled

Glaucoma Lung Problems Bleeding Problems Heart Problems Stomach/Bowel Problems

Kidney Problems Liver Problems HIV Positive Use Plaquenil Prolonged use of Steroids

Use Tobacco Use Alcohol Other Serious Medical Problem _____

Reason for today's visit:

Cataract Evaluation Routine Eye Exam Surgery to reduce your dependency on glasses/contacts

Other: _____

HOW WERE YOU REFERRED TO US

Friend/Family/Acquaintance, Name: _____

Were you referred by a doctor? Name: _____

Specialty _____ Address _____ City, State, Zip _____ Phone # _____

TV, Channel _____ Radio, Station _____ Magazine _____ Internet Paper

Other: _____

PLEASE TURN OVER AND COMPLETE THE BACK OF THIS FORM

PRIMARY HEALTH INSURANCE INFORMATION

Insurance Co _____

Address _____

ID _____ Group _____

Subscriber _____ DOB _____

Social Security # _____

Employer _____ Phone _____

Relationship to patient: Self Spouse Parent**SECONDARY HEALTH INSURANCE INFORMATION**

Insurance Co _____

Address _____

ID _____ Group _____

Subscriber _____ DOB _____

Social Security # _____

Employer _____ Phone _____

Relationship to patient: Self Spouse Parent**Attention Medicare Patients:**

Medicare patients are responsible for their deductible and the 20% copayment that Medicare does not pay. If you have met any portion of your yearly \$1) 5 deductible, please bring a copy of your Medicare EOMB which shows how much you have met. You may also be responsible for a \$40 refraction fee that is usually never covered by Medicare or any other insurance.

Attention All Patients:

Payment is due at the time of service.

Method of payment: Cash Check Credit Card: MC/Visa/AMEX/Discover

I understand that I am responsible for my bill even in the event my insurance denies my claim. I request payment of authorized insurance benefits be made on my behalf to the Key-Whitman Eye Center and the Key-Whitman Surgery Center for any services furnished to me. I further request that supplemental insurance benefits filed on my behalf be paid as stated above. I authorize direct payments by insurance companies to my physicians, and the ASC facility and I release any information acquired in the course of my examination or treatment to those insurance companies. I authorize any holder of medical information about me to release to any insurance company and its agents any information needed to determine these benefits payable for related services. I authorize release of my medical records to my primary care physician.

I have been given the opportunity to read the "Patient Information Privacy Notice" for the Key-Whitman Eye Center and the Key-Whitman Surgery Center.

Signature _____ Date _____

Notice concerning complaints:

Complaints about physicians as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address: Texas State Board of Medical Examiners, Attention: Investigations, 1812 Centre Creek Dr., Suite 300, P.O. Box 149134, Austin, TX 78714-9134, 1-800-201-9353.

Complaints regarding Key-Whitman Surgery Center may be registered with the Department of State Health Services Facility Licensing Group, 1100 West 49th St., Austin, TX 78756, 1-888-973-0022.

Thank you for choosing Key-Whitman Eye Center & Key-Whitman Surgery Center today!

Patient Record of Disclosure

The HIPAA privacy rule gives individuals the right to request a restriction on notes and disclosure of their protected health information (PHI). The individual is also granted the right to request confidential communications, or that a communication be made by alternative means.

I wish to be contacted in the following manner: (check all that apply)

By my home telephone, my number is: _____

It is ok to leave me a message with detailed information.

It is NOT ok to leave me a message with detailed information.

It is ok to contact me at work and my number is: _____

It is ok to leave me a message at work with detailed information.

It is NOT ok to leave me a message at work with detailed information.

It is ok to leave a call back number only at my work number.

I authorize you to discuss my medical history and release any and all medical information to the following individuals: (fill in all that apply)

My spouse, whose name is: _____ phone _____

My parent, whose name is: _____ phone _____

No one other than myself

Fill in any other name you desire: _____

Patient Signature: _____

Printed Name: _____

Date of Birth: _____

Name of legal guardian/caretaker: _____