Kannarr Eye Care
Patient Information

Name: _____ Birth Date: ____/____/_____
First *Middle* *Last*

Address: _____ Home Phone: _____

_____ Cell Phone: _____
City State Zip Texting okay? □ Yes □ No

Social Security #: _____/ ____/ _____ Email: _____

Sex: Male Female Marital Status: Married Divorced Single Widowed Separated

Employer: _____ Occupation: _____ Work Phone: _____

Name of Medical Doctor: _____ Medical Dr's Phone: _____

Other current medical professionals I see: _____

Responsible Party/Parental Access or Legal Guardians:

Name: _____ Relationship to patient: _____
First *Middle* *Last*

Address: _____ Phone: _____

_____ Social Security #: _____

Employer: _____ Date of Birth: _____

Demographics:

The government requires that we collect certain demographic data on our patients. Sometimes this information is helpful for your care as some eye disease are more prevalent in certain demographic populations.
Please circle your response below:

Preferred language: English Spanish Other: _____

My Race is: White Black/African American American Indian/Alaska Native Asian
Native Hawaiian/Other Pacific Islander Other Race Unknown

Ethnicity: Not Hispanic or Latino Hispanic

Pharmacy:

In efforts to keep the most up-to date medical records we would like your permission to access your pharmacy's record of current medications. This will allow our system to automatically update when you have started a new medication or discontinued an old medication. This helps our doctors provide the best care for you. Please indicate below if you allow us to contact your pharmacy for this information:

□ Yes, _____ □ No
Pharmacy name

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Insurance Information:

If you need assistance in filing insurance claims for your visits to our office, please fill out the following information and present your cards for us to copy. All prior authorizations and referrals are the patient's/guardians responsibility. Payments are not received from your insurance company within 60 days it will be forwarded to you. Payment in full for all services are ultimately your responsibility whether your insurance company chooses to cover the services or pays for only a portion of the fees charged.

Primary Medical Insurance: _____ Policy Holder: _____

Secondary Medical Insurance: _____ Policy Holder: _____

Vision Insurance Company: _____ Policy Holder: _____

Assignment and Release:

I hereby authorize payment directly to Kannarr Eye Care for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above provider location in this office to release any information required for utilization review and for obtaining payments of benefits. I authorize the use of this signature on all insurance submissions. A copy is as valid as the original. This release is valid until I request in writing this release be terminated.

Release of Information:

To ensure the finest care possible, I hereby authorize Kannarr Eye Care to release information from my records to other medical professionals for the purpose of better informing my other physicians of my current health and visual status. This also allows the doctor's to receive information from other medical professionals to better my care. This release is valid until I request in writing this release be terminated.

Access to Treatment:

The following persons are allowed to seek treatment on behalf of this patient and may discuss the patient's care with the doctors. This release is valid until I request in writing this release be terminated.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Noticy of Privacy Practices:

I acknowledge that a copy of Kannarr Eye Care's Privacy Practices was provided offered to me.

My Signature is for acceptance of all above statements regarding my care:

Signature: _____ Date: _____

Printed Name: _____ Relationship *(if other than self):* _____

Elective Screening:

Please review our Optomap Retinal Exam handout for more details regarding this technology. After reviewing please let us know whether you choose to participate in this elective screening:

□ Yes, (elective charge $15)
□ I am interested, but have a few more questions I would like to discuss with my doctor
□ Unsure at this time