Patient Information

Patient

Last Name: _____ First Name: _____ MI:___

Address: _____ City: _____ State: ___ Zip Code:____

SSN: _____ DOB: _____ Marital Status: ( )Single ( )Married ( )Other

Gender: ( )Male ( )Female Home#:_____Cell#:_____

Work#:_____ E-Mail:_____

Emergency Contact:

Name: _____ Ph#: _____ Relationship: _____

If patient is a child or adolescent, please provide the following information:

Parent/Legal Guardian: _____ Relationship:_____

Cell#:_____ Work#:_____ DOB: _____

Other Information: (You may decline to provide this information)

Race: _____ Ethnicity : _____ Language : _____

Referring Physician Information:

Physician Name: _____ Ph#: _____ Fax: _____

Insurance Information:

Insured Party: ( ) Self ( ) Spouse ( ) Mother ( ) Father ( ) Other _____

Primary Insurance: _____ Policy# _____

*Policy Holder: _____ DOB if different from insured _____

Secondary Insurance: _____ Policy#_____

*Policy Holder: _____ DOB if different from insured _____

Vision Plan Insurance: _____Policy #: _____

*Policy Holder: _____DOB if different from insured _____

ALL AMOUNTS DUE THAT ARE NOT COVERED BY INSURANCE WILL BE COLLECTED AT TIME OF VISIT

Patient Initials: _____ Date:_____

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Patient Medical History

Patient Name:_____ **DOB:**_____

Name of Previous Eye Doctor:_____ Primary Care Physician:_____

Phone#:_____

Do you have any of the following?

___Dry Eyes ___Eye Surgeries ___Wear Glasses

___Blurred Vision ___Eye Injuries ____Wear Contacts

Do you have problems with any of these systems?

___ Gastrointestinal ___Nervous System ___Mental

___Ear/Nose/Throat ___Genitourinary ___ Cardiovascular

___Allergic/Immunologic ___Respiratory ___High Cholesterol

___Blood /Lymph ___Musculoskeletal ___Headaches

___Skin

___Diabetes/Endocrine How Long?_____ ___Blood Pressure How Long?_____

Family History(Immediate Only)

___Diabetes ___High Blood Pressure ___Cataracts

___Glaucoma ___Macular Degeneration ___Retinal Detachment

Please list any major surgery you've had:

_____

Any drug allergies? Please List:

_____

Preferred Pharmacy & Location:

_____

Do you smoke?___ How much?_____ Do you drink?___ How much?_____

Interested in contact lenses? Yes or No

Please list medications:

_____

Initials:_____ **Date:**_____

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Financial & Authorization of Treatment

Thank you for choosing KDW Eye Consultants as your health care provider. The following information is provided for your benefit so that we may serve you better. We ask that all patients read and sign policy form.

Payments: I understand that I am responsible for payment of any services rendered to me or my dependents provided by this office. Appointments may be rescheduled for non-payment of co-pays and/or previous balances.

Returned Checks: Returned checks will be subject to collection charges.($30 fee)

Insurance: Your insurance policy is a contract between you, your employer (if applicable) and the insurance company. I acknowledge that the insurance cards provided are current and accurate. If there are changes, I will advise your office at the time I schedule my appointment.

Non-Covered Services: I understand that some services may not be covered by my insurance plan and I am financially responsible for all non-covered services.

Cancellation of Appointment: If you need to cancel or reschedule your appointment, please give us at least 24 hours notice. Failure to notify us in due time will result in a no-show or late cancellation fee of $40 dollars.

Refractions: Refraction is the process of determining if there is a need for corrective eyeglasses or contact lens. It is an essential part of the eye exam and necessary to receive a prescription for glasses or contact lens. A prescription is not the only purpose for a refraction, it is medically important for your eye doctor to know if any changes in your vision are occurring.

Dilation: Dilation drops are used to enlarge the pupils of the eye to allow the doctor to get a better view of inside the eye. This frequently blurs the vision for a length of time and can make bright lights bothersome. It is not possible to determine how long your vision will be affected. It is best to make arrangements not to drive yourself. Adverse reaction such as acute angle glaucoma may be triggered from the drops. It is extrememly rare and treatable with immediate medical attention.

Referrals: If your insurance requires authorization from your Primary Care Physician, we will request this ahead of time. This is done as a courtesy for you (patient), however, we can not guarantee authorization will be granted by the date of service. We will check status as your appointment gets near to make sure we have received, not receiving auth by date of service may reult in rescheduling or patient paying in full.

Signing below is an agreement to the above policies and agree to terms regarding payment responsibilities. I authorize for KDW Eye Consultants and staff to use and disclose my proctected health information for purposes of examination and/ or treatment, payment, billing and business operations.

Initials:_____ **Date:**_____

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Record Release to Family Members

Parent of/Patient's Name I,_____, do hereby authorize KDW Eye Consultants and their staff to release any and all information regarding my records from this office to the following family members:

Name:	Relationship:	Date of Birth:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Only the family members listed above shall have access to my medical information. No others shall be allowed unless I, the patient of Dr. John F. Kozlovsky, Dr. Richard L. Delay, Dr. Bruce Winter, Dr. Jeannine E. Camacho and/or Dr. Judith Newman add their names to the list above.

_____ _____

Parent of/Patient's Signature Date

KDW EYE CONSULTANTS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have recieved a notice of KDW Eye Consultants notice of Privacy Practices. **(PLEASE ASK RECEPTIONIST IF YOU WOULD LIKE A COPY OF OUR NOTICE OF PRIVACY PRACTICES FORM.)**

This notice describes how KDW Eye Consultants may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information and rights I may have regarding my protected health information.

Initials: _____