Welcome to Mesquite Eye Associates!

If you are returning, Welcome back!
Please take a few moments to fill out this form.

Name_____Employer_____Occupation_____

What brings you in today?_____

Have you ever had any of the following;
(Please check all that apply)

- ☐ Eye Injuries
- ☐ Eye Infections
- ☐ Amblyopia (lazy eye)
- ☐ Eye Turn
- ☐ Seen Flashes
- ☐ Seen Floaters
- ☐ Thyroid disorder
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Cancer
- ☐ Allergies

Please note any history for yourself/ family for the following;

Disease/Condition	No	Yes	Relationship
☐ Cataracts	☐	☐	_____
☐ Glaucoma	☐	☐	_____
☐ Retinal Disease	☐	☐	_____
☐ Retinal Detachment	☐	☐	_____
☐ Macular Degeneration	☐	☐	_____
☐ Diabetes	☐	☐	_____

Any other medical conditions not listed above?_____

Please list any current medications_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ acknowledge that I have received a copy of Mesquite Eye Associates "Notice of Privacy Practices."
(NAME)
This Notice describes how Mesquite Eye Associates 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 information.

_____
(Signature of Patient, or Guarantor)

MEDICAL RELEASE

I, _____ give my permission for Mesquite Eye Associates to receive medical records from my physicians or give my medical records to any physician that Dr. Karl Kutch or any of his associates refer me to.

_____ Date_____
(Signature of Patient, or Guarantor)

_____
(Relationship to Patient)

FINANCIAL RESPONSIBILITIES

This office may be billing insurance claims on behalf of the patient. If, for any reason your insurance does not pay for any services you have received, you (the patient or guarantor) will be responsible for any and all charges. If, you do not pay your balance in full there could be additional fees, service charges or interest assessed to your bill.
**Vision plans cannot be billed for any patient being seen with a medical eye conditions.

_____
(Signature of Patient or Guarantor)

EMAIL ADDRESS: _____