Welcome to our office!

Thank you for choosing Kiowa Eye Care Center. We are delighted to have you as a patient and appreciate the confidence you have placed in us.

Name: _____ Birth Date: ____/ ____/ ____ Sex: M F

Street: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Employer: _____

If minor: Responsible Party Name: _____ Relationship: _____

Preferred phone: _____ e-mail: _____

Marital Status (circle one): married single partnered Name of spouse/partner: _____

Payment & Insurance Information:

Full payment is expected when services are rendered. If you have medical insurance or a vision plan, we are happy to help you receive your maximum allowable benefit.
YOU MUST REALIZE, HOWEVER, THAT:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- Not all services are a covered benefit in all contracts with insurances. Some insurance companies arbitrarily select certain services they will not cover.
- The adult accompanying a minor child is responsible for full payment at the time of service. Kiowa Eye Care Center is not party to any legal agreements between divorced or separated parents.
- We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend our patients, all charges are your responsibility from the date the services are rendered.

MEDICAL INSURANCE INFORMATION:
Cardholder name: _____ Relationship to patient: _____
Cardholder date of birth: _____ Cardholder's last 4 of SSN: _____
Insurance Company: _____ Insured ID #: _____

VISION PLAN INFORMATION:
Cardholder name: _____ Relationship to patient: _____
Cardholder date of birth: _____ Cardholder's last 4 of SSN: _____
Insurance Company: _____ Insured ID #: _____

I _____authorize the release of all medical information necessary to process claims and assign medical/ vision benefits to Kiowa Eye Care Center. I acknowledge that all the above information above is correct and that I am fully responsible for all charges to my account.

Signed: _____ Date: _____

What is the best way to contact you?

In order to protect your privacy; please indicate the methods we may use to contact you:

Home phone: _____ Is it OK to leave a message at this number? Yes No

Work phone: _____ Is it OK to leave a message at this number? Yes No

Cell phone: _____ Is it OK to leave a message at this number? Yes No

Eye Health History

Eye surgeries: cataract/ glaucoma/ retinal/ cosmetic/ LASIK/ PRK/ RK other? _____

Have you ever been diagnosed with: cataracts/ glaucoma/ macular degeneration/ other? _____

Do you use eye drops? _____

General Health Information:

Current Height: _____ft _____in		**Current Weight**: _____lbs.
YES	NO	
		1. General: Fever, Chills, Weakness, Unusual Weight Loss/Gain
		2. Ear Nose Thorat: Hearing Loss, Sinusitis, Dry Mouth, Laryngitis
		3. Psychological: Depression, Attention Deficit, Anxiety Disorder, Bipolar Disorder
		4. Cardiovascular: High Blood Pressure, Stroke, Heart Disease, Vascular Disease, Congestive Heart Failure
		5. Respiratory: Cigarette Smoker, Asthma, Bronchitis, Emphysema, Chronic Obstruction, Sleep Apnea
		6. Gastro Intestinal: Crohn's, Colitis, Ulcer, Acid Reflux, Celiac Disease
		7. Genital/ Urinary: Kidney Disease, Prostate Disease/ Cancer, Sexually Transmitted Disease (Herpes/ Chlamydia), Pregnancy
		8. Musculoskeletal Arthritis, Osteoarthritis, Fibromyalgia, Muscular Dystrophy, Anklosing Spondylitis, Osteoporosis, Gout
		9. Skin Eczema, Rosacea, Psoriasis, Herpes Simplex/ Cold Sores, Herpes Zoster/ Shingles
		10. Endocrine Type 1 Diabetes, Type 2 Diabetes, Thyroid Dysfunction, Hormonal Dysfunction
		11. Blood Disorders Anemia, Large-Volume Blood Loss, Ulcer, Hypercholestermia
		12. Allergy Drug Allergies, Environmental Allergies, Rheumatoid Arthritis, Lupus, Sjogren's Syndrome

Family History

Cancer	father	mother	brother	sister	son	daughter
Diabetes Type 1	father	mother	brother	sister	son	daughter
Diabetes Type 2	father	mother	brother	sister	son	daughter
Hypertention	father	mother	brother	sister	son	daughter
Hyperthyroidism	father	mother	brother	sister	son	daughter
Hypothrroidism	father	mother	brother	sister	son	daughter
Cataract	father	mother	brother	sister	son	daughter
Macular Degeneration	father	mother	brother	sister	son	daughter
Glaucoma	father	mother	brother	sister	son	daughter
Other Eye Diseases:						

Medications

Please list all medications you are currently taking:

Drug Allergies: _____