Welcome to our Office!

The Eye Clinic LLC

Dr. Kevin K.E. Carl – Dr. Desmon Carl

Optometrists

Confidential Information for the Doctor Thank you for completing entire form

(If you are already a patient here, make corrections if necessary.)

Name_____ Age_____

Last First Middle Male _____ Female _____

Address_____ Cell/Home _____

E-mail _____ Texting Available _____

City_____ State_____ Zip Code_____

SS #_____ DOB_____ Occupation_____

Business Phone_____ Employed By_____

If Student, name of school_____ Parent/Guardian_____

Insurance_____ Policy #_____

Policy Holders Name_____ DOB_____

Spouses Name_____ SS # _____

Employed By _____Business Phone_____

Child/Children Names_____ Ages_____

Emergency Contact_____ Phone #_____

Whom may we thank for referring you? _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Dr. Kevin Carl and/or Dr. Desmon Carl of all insurance benefits otherwise payable to me for the 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 Dr. Kevin Carl and/or Dr. Desmon Carl to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party_____ Date: _____

ONE TIME AUTHORIZATION

Name of Beneficiary: _____ HI Claim Number_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Kevin Carl and/or Dr. Desmon Carl for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agent any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature_____ Date Signed_____

ACKNOWLEDGEMENT OF RECEIPT

Our Privacy Practice policy is available for anyone who would like a copy, just inform the front desk if you would like a copy. Please sign below even if you choose not to receive a copy of our Privacy Practice policy.

I acknowledge that I received a copy of Dr. Kevin Carl and/or Dr. Desmon Carl's notice of Privacy Practices. Date:_____

Print Patient Name: _____ Signature: _____

Please fill out the following to the best of your knowledge.

Name: _____ Date: _____

Last Eye Exam: _____ Last Eye Doctor: _____

Last Medical Exam: _____ Current Medical Dr.: _____

Pharmacy: _____

Medical History

Do you have any allergies to medications? _____Yes _____ No If yes, explain: _____

_____

List any medications you take (including oral contraceptive, aspirin, over the counter medications, and home remedies):

_____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Circle any of the following that you have had: **crossed eyes, lazy eye, glaucoma, retinal disease, cataracts, or eye injury**.

Are you pregnant and/or nursing? _____Yes _ _ _No

Do you wear glasses? _____Yes _____No If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? _____Yes _____No If yes, how old is your present pair of lenses? _____

Type of contact lenses: ____Rigid _____Soft _____Extended Wear _____Other Are they comfortable? _____Yes _____No

Have you had refractive surgery? _____ Yes _____No

Family History

Have any of your relatives, living or deceased, had any of these conditions?

Ocular Disease/Condition	**Yes**	**No**	**Not Sure**	**Relationship to You**
Blindness	_____	_____	_____	_____
Cataract	_____	_____	_____	_____
Crossed Eyes	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____
Macular Degeneration	_____	_____	_____	_____
Retinal Detachment/Disease	_____	_____	_____	_____
Systemic Disease/Condition				
Arthritis	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____
Lupus	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____

Other _____

Please turn this form over and complete side two*

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

_____Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive? _____Yes _____No
If yes, do you have visual difficulty when driving? _____Yes _____No if yes, please describe:

Height_____ Weight_____

Do you use tobacco products? _____Yes _____No If yes, Type/Amount/How long?_____

Do you drink alcohol? _____Yes _____No If yes, Type/Amount/How long?_____

Do you use illegal drugs? _____Yes _____No If yes, Type/Amount/How long?_____

Have you ever been exposed to or infected with: ___Gonorrhea ___Hepatitis ___HIV ___Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

System	Yes	No	Not Sure
Constitutional			
Fever, Weight Loss/Gain	_____	_____	_____
Skin (Integumentary)	_____	_____	_____
Neurological			
Headaches	_____	_____	_____
Migraines	_____	_____	_____
Seizures	_____	_____	_____
Eyes			
Loss of Vision	_____	_____	_____
Blurred Vision	_____	_____	_____
Distorted Vision/Halos	_____	_____	_____
Loss of Side Vision	_____	_____	_____
Double Vision	_____	_____	_____
Dryness	_____	_____	_____
Mucous Discharge	_____	_____	_____
Redness	_____	_____	_____
Sandy or Gritty Feeling	_____	_____	_____
Itching	_____	_____	_____
Burning	_____	_____	_____
Foreign Body Sensation	_____	_____	_____
Excess Tearing/Watering	_____	_____	_____
Eye Pain or Soreness	_____	_____	_____
Glare/Light Sensitivity	_____	_____	_____
Chronic Infection of eye or Lid	_____	_____	_____
Sties or Chalazion	_____	_____	_____
Flashes/Floaters in Vision	_____	_____	_____
Tired Eyes	_____	_____	_____
Endocrine			
Thyroid/Other Glands	_____	_____	_____

System	Yes	No	Not Sure
Ears, Nose, Mouth, Throat			
Allergies/Hay Fever	_____	_____	_____
Sinus Congestion	_____	_____	_____
Runny Nose			
Post-Nasal Drip	_____	_____	_____
Chronic Cough	_____	_____	_____
Dry Throat/Mouth	_____	_____	_____
Respiratory			
Asthma	_____	_____	_____
Chronic Bronchitis	_____	_____	_____
Emphysema	_____	_____	_____
Vascular/Cardiovascular			
Diabetes	_____	_____	_____
Heart Pain	_____	_____	_____
High Blood Pressure	_____	_____	_____
Vascular Disease	_____	_____	_____
High Cholesterol	_____	_____	_____
Gastrointestinal	_____	_____	_____
Genitals/Kidney/Bladder	_____	_____	_____
Bones/Joints/Muscles	_____	_____	_____
Rheumatoid Arthritis	_____	_____	_____
Muscle Pain	_____	_____	_____
Joint Pain	_____	_____	_____
Lymphatic/Hematologic	_____	_____	_____
Anemia	_____	_____	_____
Bleeding Problems	_____	_____	_____
Allergic/Immunologic	_____	_____	_____
Psychiatric	_____	_____	_____
Depression	_____	_____	_____
Anxiety	_____	_____	_____