RBK ___ DBM ___ Date _____ Major medical _____ Chart # _____

Last name, first name and middle initial		Home phone
Address		Cell phone
City, State, and Zip		Work phone
Date of birth	Social Security #	Occupation/employer
Emergency contact name & phone #		
May we email you? If "Yes", email address _____ Whom may we thank for referring you?		

Who is your primary care insurance provider? _____

Policy holder's: a) name _____;

b) date of birth _____, and; c) Social Security # _____.

Do you have a separate vision coverage plan such as VSP or EyeMed? ___ Yes ___ No

If yes, policy holder's: a) name _____;

b) date of birth _____, and; c) Social Security # _____.

Medications you are currently taking	
Medications to which you are allergic	
Name of family physician	Date of last medical exam

Please check all that apply and explain below

____ High blood pressure	____ Diabetes Type 1	____ Genito-urinary problems
____ High cholesterol	____ Diabetes Type 2	____ Cancer
____ Heart issues	____ Thyroid problems	____ Eczema
____ Ocular allergies	____ Asthma	____ Rosacea
____ Nasal allergies	____ Breathing problems	____ Allergic dermatitis
____ Serious anaphylaxis reaction	____ Gastrointestinal problems	____ Headaches
____ Anemia	____ Musculoskeletal problems	____ Brain trauma
____ Leukemia	____ Immunological problems	____ Depression
____ Other bleeding problems	____ Ear, nose, throat problems	____ Anxiety

____ Other medical issue not listed

Please provide an explanation of any issues you checked in the list above and any other medical issues not listed above

____ Currently pregnant (if so, # of months _____)	____ Currently nursing
____ Currently smoking (if so, # of cigarettes per day _____)	
____ Currently consuming alcohol (if so, # of ounces per day _____)	____ Using recreational drugs

What eye problems to you have? (yourself)	Family medical & eye history (your mother, father, sister, brother, son or daughter)	
	Condition	Relationship
____ I have had LASIK / PRK (year _____)	____ Diabetes	_____
____ I have/had Cataracts ____ I had Cataract surgery	____ High blood pressure	_____
____ I have "Floaters" or "Flashes of light"	____ Glaucoma	_____
____ I have glaucoma (high pressure within the eye)	____ Cataracts	_____
____ I have macular degeneration	____ Macular degeneration	_____
____ I have retinal detachment(s) ___ Left ___ Right	____ Retinal detachment	_____
____ I have a lazy eye(s) ___ Left ___ Right	____ Lazy eye / crossed eye	_____
____ I have dry eyes	____ other eye condition	_____
____ I have watery eyes ____ I have red eyes		

Reason(s) for today's visit (check all that apply):

____ Routine eye exam ____ New glasses ____ Computer glasses ____ Contact lenses

____ Medical eye treatment ____ Interested in refractive surgery ____ Other (explain)

I am interested in contacts, either now or in the future: ____ Now ____ Future ____ Neither

Disclosure of Confidential Information Authorization

Please read carefully. I understand that my medical records are confidential. I understand that by signing this consent form, I am allowing my medical information to be released upon request to any insurance provider for the purpose of Health Care Operations (including, but not limited to, provider review functions, claims payment, and quality assessment). I also understand that I may revoke this consent by written request at any time, with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

For additional information on VSP's Patient Confidentiality Policy, please refer to www.vsp.com. VSP updates the patient confidentiality policy periodically and reserves the rights to make changes as required.

I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing. I also understand that my request for restriction may be denied if the information is required for health care operations.

Patient signature _____ Date _____

Other Insurance Authorization and Acknowledgement

Patient's printed name _____

I authorize the release of any medical information necessary to process the insurance claim.
I hereby authorize payment of medical benefits if any, to Kennedy Eye Associates.
I understand that I am responsible for any fees that my insurance company does not cover.
I have been provided with an opportunity to review the confidentiality policy of Kennedy Eye Associates.
I have reviewed, and I understand, the above statements and agree to them.

Patient signature _____ Date _____

Patient signature _____ Date _____

Patient signature _____ Date _____

Patient signature _____ Date _____

Patient signature _____ Date _____

Patient signature _____ Date _____

Patient signature _____ Date _____