SOMERS EYE CENTER PATIENT HEALTH HISTORY

Name _____ Date _____

Please state the reason(s) for your visit _____

Duration of symptoms/problems _____ Referred by _____

Allergies to medications _____

Current medications _____

_____

Social History: Smoke Y N Packs per day _____

Alcohol intake: None Occasional Daily Amount _____

Past Medical History: (check if applicable)

Diabetes	_____	Asthma/lung disease	_____	Hearing problem	_____
High blood pressure	_____	Digestive disorder	_____	Thyroid disease	_____
Heart disease	_____	Psychiatric disorder	_____	Arthritis	_____
Blood disorder	_____	High cholesterol	_____	Stroke	_____
Liver disease	_____	Skin disease	_____	Seizures	_____
Migraine headaches	_____	Cancer	_____	Skin	_____

Please list any surgeries or hospitalizations with the date of occurrence

_____

_____

Past Eye History: (check if applicable)			Right	Left	Year
Glasses	_____	Cataract Surgery	_____	_____	_____
Cataracts	_____	Retinal detachment	_____	_____	_____
Retinal disease	_____	Laser Surgery	_____	_____	_____
Macular degeneration	_____	Corneal transplant	_____	_____	_____
Glaucoma	_____	Refractive Surgery	_____	_____	_____

Family History: (please indicate (P) parents (S) siblings (C) children if any relatives have the following medical conditions)

Diabetes	_____	Arthritis	_____
Cancer	_____	Blindness	_____
Glaucoma	_____	Stroke	_____
Asthma	_____	High blood pressure	_____
Allergies	_____	Heart disease	_____
Macular degeneration	_____		

Somers Eye Center
Health Services Pavilion • NKC Hospital
790 Clay Edwards Dr., Ste. 1240
North Kansas City, MO 64116

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SOMERS Eye Center

PATIENT INFORMATION FORM

Last Name_____ **First Name**_____ **Middle Initial**____

Mailing Address_____

City, State, Zip Code_____

Social Security # _____ **Date of Birth** _____

Home #_____ **Work#**_____ **Cell#**_____

Email Address_____

Employer_____

Pharmacy of Choice_____

Location_____ **Phone#**_____

Primary Care Physician—Name_____

Address_____

Phone_____ **Fax**_____

Please Circle: Single Married Divorced Widowed Please Circle: Student Retired Disabled

INSURANCE INFORMATION

Primary Insurance Company_____

Subscriber's Name/D.O.B. _____

ID#_____ **Group#**_____

Secondary Insurance Company_____

Subscriber's Name/D.O.B._____

ID#_____ **Group#**_____

PAYMENTS OF BENEFITS/MEDICAL RELEASE AUTHORIZATION/RESPONSIBLE PARTY SETTLEMENT
I AUTHORIZE PAYMENT OF BENEFITS AS DETERMINED BY MY INSURANCE DIRECTLY TO SOMERS EYE CENTER. **I authorize release of any information necessary to process my insurance claim. As the responsible party, I agree that all charges not directly paid by my insurance are my responsibility.**

X_____ **DATE**_____
Signature