PATIENT INFORMATION

LAST NAME: _____ **FIRST NAME:** _____ **MIDDLE INT:**____

MAILING ADDRESS:_____

CITY, STATE, ZIP CODE:_____

GENDER: _____ **MARITAL STATUS:** SINGLE /MARRIED /WIDOWED /DIVORCED

DATE OF BIRTH: _____ **SOCIAL SECURITY#:**_____

PREFERRED LANGUAGE: _____ **RACE/ETHNICITY:**_____

EMPLOYER:_____

CONTACT INFO:

HOME #: _____ Call 1st / Call 2nd / Call 3rd

WORK #: _____ Call 1st / Call 2nd / Call 3rd

CELL#: _____ Call 1st / Call 2nd / Call 3rd

EMAIL ADDRESS: _____

I PREFER TO BE CONTACTED BY: PHONE CALL / EMAIL / TEXT / _____

PRIMARY INSURANCE CARRIER: _____

INSURANCE ID: _____ **GROUP #:**_____

POLICY HOLDER NAME (if not yourself): _____

RELATIONSHIP:_____**DATE OF BIRTH:**_____**SOCIAL SECURITY #:**_____

RESPONSIBLE PARTY NAME (if not yourself):

NAME:_____

ADDRESS:_____

PHONE #: _____

PRIMARY CARE PHYSICIAN NAME: _____

PRACTICE NAME:_____

PHONE #: _____**FAX #:** _____

PHARMACY OF CHOICE: _____ **LOCATION:**_____

PHONE #:_____**FAX#:**_____

PATIENT SIGNATURE: _____ **DATE:** _____

PATIENT HEALTH HISTORY

VACCINATIONS /IMMUNIZATIONS: (PLEASE CIRCLE ALL THAT APPLY)

1. PNEUMOCOCCAL VACCINATION (PNEUMONIA SHOT): YES / NO / UNSURE
2. INFLUENZA IMMUNIZATION (FLU SHOT) within the last 1 year: YES / NO / UNSURE
3. COVID VACCINATION: YES / NO / UNSURE

PAST MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

ARTHRITIS----------ASTHMA/LUNG DISEASE----------BLINDNESS----------BLOOD DISORDER --------
CANCER------DIABETES-------DIGESTIVE DISORDER--------GLAUCOMA-------HARD OF HEARING-----
KIDNEY DISEASE------HEART DISEASE------HIGH BLOOD PRESSURE------HIGH CHOLESTEROL------
LIVER DISEASE----------MACULAR DEGENERATION----------MIGRAINE/ HEADACHES----------
PSYCHIATRIC DISORDER---------SEIZURES------SEASONAL ALLERGIES----------SKIN DISEASE------
STROKE ----------**NONE** (Circle if you do not have any medical problems)

SURGERIES/ HOSPITALIZATIONS: Please list with DATES (if known), or circle all that apply:

_____**Please see the list I brought in**
_____**I don't know my Surgeries/Hospitalizations**
_____ **I have never had any Surgeries/Hospitalizations**
_____
_____
_____

CURRENT MEDICATIONS: Please list all medications, or circle all that apply:

_____**Please see the list I brought in**
_____**I don't know my medications**
_____**I don't take ANY medications**
_____
_____
_____
_____

ALLERGIES TO MEDICATIONS: Please list all allergies, or circle all that apply:

_____**Please see the list I brought in**
_____**I don't know my allergies**
_____ **I don't have ANY allergies**
_____

FAMILY MEDICAL HISTORY:

PLEASE INDICATE BY **CIRCLING WHICH FAMILY MEMBER** HAD THE MEDICAL CONDITION(S):
(M) MOTHER, **(F)** FATHER, **(GM)** GRANDMOTHER, **(GF)** GRANDFATHER,
(SS) SISTER, **(B)** BROTHER, **(A)** AUNT, **(U)** UNCLE, **(S)** SON, **(D)** DAUGHTER

ARTHRITIS: M/ F/ GM/ GF/ SS/ B/ A/ U/ S/ D----------**ALLERGIES:** M/ F/ GM/ GF/ SS/ B/ A/ U/ S/ D

ASTHMA: M/ F/ GM/ GF/ SS/ B/ A/ U/ S/ D----------**BLINDNESS:** M/ F/ GM/ GF/ SS/ B/ A/ U/ S/ D

CANCER: M/ F/ GM/ GF/ SS/ B/ A/ U/ S/ D----------**DIABETES:** M/ F/ GM/ GF/ SS/ B/ A/ U/ S/ D

GLAUCOMA: M/ F/ GM/ GF/ SS/ B/ A/ U/ S/ D---------**HEART DISEASE:** M/ F/ GM/ GF/ SS/ B/ A/ U/ S/ D

HIGH BLOOD PRESSURE: M/ F/ GM/ GF/ SS/ B/ A/ U/ S/ D----------

MACULAR DEGENERATION: M/ F/ GM/ GF/ SS/ B/ A/ U/ S/ D----------

STROKE: M/ F/ GM/ GF/ SS/ B/ A/ U/ S/ D----------

OTHER MEDICAL CONDITIONS NOT LISTED ABOVE:_____

_____

NO ONE in my family has any medical problems ----------**UNKNOWN** (I don't know of any / I was adopted)

SOCIAL HISTORY:

(PLEASE CIRCLE WHAT APPLIES IN EACH ROW)

MARITAL STATUS: SINGLE/ MARRIED/ DIVORCED/ WIDOWED

TOBACCO USE: NEVER

FORMER (**DATE QUIT**_____) – **great job quitting!**

YES (**DAILY AMOUNT**_____)

TYPE: (cigarettes, pipe, vape, chewing tobacco, etc.)_____

Please note that Drs. Somers and Blacklock strongly recommend not smoking, as it causes damage throughout your body, including to your eyes!

ALCOHOL INTAKE: NONE

OCCASIONAL/SOCIAL

1-2 DRINKS A DAY

3-4 DRINKS A DAY

OTHER DAILY AMOUNT_____

OCCUPATION: WORKING / STUDENT / RETIRED / DISABLED / UNEMPLOYED

if working, my occupation is_____

FALL RISK: Do you feel you are at risk to fall, or have you fallen in the last year? YES / NO

REASON FOR YOUR VISIT TODAY: _____

_____

DURATION OF SYMPTOMS/ PROBLEMS: _____

Please list anything that you are currently using <u>in your eyes</u> (drops, ointments, saline, etc.):

_____

_____

<u>EYE HISTORY:</u>	**<u>(PLEASE CIRCLE WHAT APPLIES):</u>**		
GLASSES:	CURRENT / PAST / NEVER		
CONTACT LENSES:	CURRENT / PAST / NEVER		
CATARACTS:	RIGHT / LEFT / BOTH / NEVER		
CATARACT SURGERY:	RIGHT / LEFT / BOTH / NEVER		
RETINAL DISEASE:	R / L / B / No	**REFRACTIVE SURGERY:**	R / L / B / No
RETINAL SURGERY:	R / L / B / No	**LASER SURGERY:**	R / L / B / No
RETINAL DETACHMENT:	R / L / B / No	**CORNEAL TRANSPLANT:**	R / L / B / No

How did you hear about us? Did someone specific refer you to us that we could thank with your permission? _____

REFERRED BY: _____

THANK YOU FOR COMPLETING THESE FORMS AND HELPING US PROVIDE YOU WITH THE BEST CARE POSSIBLE!

PATIENT SIGNATURE: _____ **DATE:** _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____

SOMERS EYE CENTER
HIPAA COMPLIANCE AUTHORIZATION
FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

By signing this form I authorize the use and disclosure of my health information as described in the Notices of Privacy Practices. I have been given a copy of the Notice of Privacy Practices to read and keep if I desire.

To revoke this authorization, I must do so in writing and send to:

SOMERS EYE CENTER
Attention: HIPAA Compliance Officer
2790 Clay Edwards Dr. Ste 1240
North Kansas City, MO 64116

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the federal Privacy Standards.

I authorize Somers Eye Center to:

_____ **Speak directly to me (Do not give information to anyone else).**

_____ **May leave a message. PHONE NUMBER:** _____

_____ **May disclose information to the following person(s):**

NAME: _____ PHONE NUMBER: _____ RELATIONSHIP: _____

NAME: _____ PHONE NUMBER: _____ RELATIONSHIP: _____

PATIENT SIGNATURE: _____ **DATE:** _____