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:_____
HOME #: _____**WORK #:** _____**CELL#:**
EMAIL ADDRESS:

ALTERNATIVE CONTACT PERSON:
NAME:_____ **RELATIONSHIP:**
HOME #: _____ **WORK #:** _____ **CELL#:**

EMAIL ADDRESS:

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:_____
PHONE #: _____
ADDRESS:_____

PRIMARY CARE PHYSICIAN NAME:
PRACTICE NAME:_____
if known: PHONE #: _____**FAX #:**

PHARMACY OF CHOICE: _____**LOCATION:**
if known: PHONE #:_____**FAX#:**_____

PATIENT SIGNATURE: _____ **DATE:**

PATIENT HEALTH HISTORY

VACCINATIONS /IMMUNIZATIONS: (PLEASE CIRCLE ALL THAT APPLY)

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

PAST MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

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

<u>OTHER MEDICAL CONDITIONS NOT LISTED ABOVE:</u> _____

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

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

<u>CURRENT MEDICATIONS:</u> Please <u>list all medications</u>, or <u>circle all that apply:</u>

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

<u>ALLERGIES TO MEDICATIONS:</u> Please <u>list all allergies</u>, or <u>circle all that apply:</u>

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

<u>FAMILY MEDICAL HISTORY:</u>

PLEASE INDICATE BY **<u>CIRCLING</u>** **<u>WHICH FAMILY MEMBER</u>** 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

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

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

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

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

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

OTHER MEDICAL CONDITIONS IN FAMILY MEMBERS NOT LISTED ABOVE:

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 Dr. Blacklock and Dr. Loughman 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 in your eyes (drops, ointments, saline, etc.):

_____

_____

EYE HISTORY: **(PLEASE CIRCLE WHAT APPLIES):**

GLASSES: CURRENT / PAST / NEVER

CONTACT LENSES: CURRENT / PAST / NEVER

CATARACTS: RIGHT / LEFT / BOTH / NEVER / UNSURE

CATARACT SURGERY: RIGHT / LEFT / BOTH / NEVER / UNSURE

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:**_____