Koury Family Eye Care – Patient Registration

Patient Name: _____ Date of Birth: _____

Address: _____ Gender: __ Male __ Female

City: _____ State: _____ Zip Code: _____ Occupation: _____

Cell Phone: _____ Home Phone: _____

Preferred contact method: __ Cell Phone __ Home Phone

In the future, we may use Text Messaging for appointment confirmations and office communications. We never share your information.

eMail Address: _____

Name of Parents (*if patient is Minor*): _____

__ DO NOT send Text messages.

Do you currently wear Glasses? __ No __ Full Time __ For Distance Only __ For Near Only __ For Computer Only __ Worn in the Past

Are you interested in wearing Contact Lenses? __ No __ Yes ⇨ __ Current Wearer __ Worn in the Past __ First Time Wearer

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INSURANCE INFORMATION

Are you covered by any of these Vision Plans? __ Davis __ Spectera __ EyeMed __ NVA __ Superior __ Avesis __ VSP

Do you have Medicare? __ No __ Yes ⇨ Medicare Supplement _____

Do you have a Medicare Advantage Plan? __ No __ Yes ⇨ With which company? _____

Do you have Medical Insurance with: __ Capital Blue Cross __ Highmark Blue Shield __ Other Blue Cross / Blue Shield

__ Aetna __ United Healthcare __ Other _____

Koury Family Eye Care provides both Routine eye examination services and Medical (health) eye care. When applicable, Koury Family Eye Care will bill in-network Vision Plans (Davis Vision, EyeMed, etc.) for routine eye examinations. However, if a medical eye condition (ie. glaucoma, eye injury, infection, diabetes, or other condition) requires evaluation, testing, or treatment, Koury Family Eye Care must bill your Medical Insurance in accordance with insurance contractual agreements.

The following statements are applicable if the patient is utilizing insurance benefits.

I authorize release of any medical information and medical records to my insurance company necessary to process a claim.
I authorize payment of benefits to be made directly to Koury Family Eye Care, LLC for services rendered to me.
I authorize use of this form on all of my insurance submissions and permit a copy of this authorization to be used in place of the original.
I understand that I am fully responsible for payment of any Co-Insurance, Co-Payments, Deductibles, and any other charges that are incurred that are not covered by my insurance.
I understand this office does not in any way guarantee payment for my exam by accepting my insurance plan.

I acknowledge that a copy of this office's *Notice of Privacy Practices* has been made available to me.

_____ _____

Signature of Patient, Guardian, or Authorized Representative *Date*

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM

Koury Family Eye Care – Medical History

Patient Name: _____ Today's Date: _____

Current Eye History: *Are **YOU** experiencing any of the following?*

__ NONE
__ Blurred Distance Vision
__ Blurred Near Vision
__ Blurred Computer Vision
__ Dry Eyes
__ Redness
__ Tearing
__ Burning
__ Contact Lens Issues
__ Eye Pain
__ Mucous/Discharge
__ Itching
__ Seeing Flashes of Light
__ Seeing Spots in Vision
__ Headaches
__ Loss of Vision
__ Glare at Night
__ Difficulty Driving
__ Double Vision
__ _____

Previous Eye History: *Do **YOU** have a history of any of the following?*

__ NONE
__ Glaucoma
__ Cataracts
__ Macular Degeneration
__ Corneal Disorders
__ Retinal Disorders
__ Strabismus (Eye Turn)
__ Amblyopia (Lazy Eye)
__ Patching
__ Eye Injury
__ Eye Surgery
__ _____

Family History: *Does anyone in **YOUR FAMILY** (Parents, Grandparents, Siblings) have a history of any of the following?*

__ NONE
__ Glaucoma
__ Macular Degeneration
__ Retinal Disorders
__ Blindness
__ Keratoconus
__ Fuch's Dystrophy
__ Strabismus (Eye Turn)
__ Amblyopia (Lazy Eye)
__ Diabetes
__ High Blood Pressure
__ _____

Systemic History: *Do **YOU** have a history of any of the following? Many systemic conditions can also affect your eyes.*

***Currently* Pregnant or Nursing**
__ No __ Yes

Constitutional
__ NONE
__ Developmental Disability
__ Cancer / Tumor
__ Fatigue Syndrome

Cardiovascular
__ NONE
__ High Blood Pressure
__ Stroke
__ Heart Disease
__ Arteriosclerosis
__ Mitral Valve Prolapse

Endocrine
__ NONE
__ Diabetes
__ Thyroid dysfunction
__ Hormonal dysfunction

Smoking History
__ Never
__ Former
__ Current

Musculoskeletal
__ NONE
__ Fibromyalgia
__ Muscular Dystrophy
__ Gout

Gastrointestinal
__ NONE
__ Crohn's Disease
__ Colitis

Genitourinary
__ NONE
__ Kidney disease
__ Prostate disease/cancer

Hematologic / Lymphatic
__ NONE
__ High Cholesterol
__ Anemia
__ Large-volume blood loss
__ Leukemia

Ears/Nose/Throat/Mouth
__ NONE
__ Hearing Loss
__ Sinusitis
__ Dry Mouth

Allergic / Immunologic
__ NONE
__ Environmental Allergies
__ Rheumatoid Arthritis
__ Lupus
__ Sarcoidosis
__ Sjögren's Syndrome

Integumentary
__ NONE
__ Eczema
__ Rosacea
__ Psoriasis

Psychiatric
__ NONE
__ Depression
__ ADD / ADHD

Neurological
__ NONE
__ Multiple Sclerosis
__ Epilepsy
__ Alzheimer's Disease
__ Seizures
__ Migraines
__ Head Injury

Respiratory
__ NONE
__ Asthma
__ Bronchitis
__ Emphysema
__ Sleep Apnea
__ COPD

Infectious
__ NONE
__ Lyme Disease
__ STD - Herpes/Chlamydia/Syphilis
__ HIV / AIDS
__ Tuberculosis
__ Hepatitis
__ Shingles

*Who is your family Physician?*_____

Medications: *(If you have a written list, our staff can copy it)*

__ NONE _____
_____
_____
_____

Allergies to Medications:

__ NONE _____
_____
_____
_____