LAWRENCE
EYE CARE
ASSOCIATES, P.A.

Dear Patient:

Enclosed you will find paperwork that you will need to complete and bring with you on the day of your scheduled appointment. **You will only need to complete this paperwork if you are a new patient or if you have not been treated since September, 2012.** This will expedite the registration process so that we can get you back to see the physician as soon as possible.

Please have your insurance card and driver's license or ID card with you so that we can take a copy for our records. If your insurance requires that you pay a co-pay, we will collect that prior to your seeing the doctor.

In addition to a co-pay, if your insurance requires that you have a referral from your primary care physician, the referral must be in place before you see the physician or we will need to reschedule the appointment.

Our goal is to make your visit go as smoothly as possible. If you have any questions prior to your scheduled appointment, please don't hesitate to call us at 785-841-2280 between the hours of 8:00am – 4:30pm, Monday through Friday.

Sincerely,
Lawrence Eye Care Associates, P.A.

Lawrence Eye Care Associates, P.A.
1112 W. 6th St., Suite 214
Lawrence, KS 66044
Office: (785) 841-2280 — Fax: (785) 841-2765

LAWRENCE EYE CARE ASSOCIATES, P.A.

PATIENT INFORMATION

FULL NAME _____ DOB ____/____/____ SSN_____–_____–_____

ADDRESS _____ CITY_____ ST____ ZIP_____

CELL PHONE (_____)_____ HOME PHONE (_____) _____ WORK (_____)_____

GENDER: __M __F __UNS MARITAL STATUS: __S __M __D __W SPOUSE NAME _____

**EMERGENCY CONTACT* _____ *RELATIONSHIP*_____ *PHONE* _____

Emergency contact will be used for emergencies only and is **NOT authorized for release of information unless listed in the Release of Information section below.*

PREFERRED LANGUAGE:
___English
___Spanish
___Other_____

RACE:
___American Indian/Alaska Native
___African American
___Asian
___White
___Native Hawaiian/Other Pacific Islander
___Other _____

ETHNICITY:
___Hispanic/Latino
___Not Hispanic/Latino

EMPLOYER _____ PHONE _____ OCCUPATION _____

IF THE PATIENT IS A DEPENDENT, PLEASE PROVIDE THE FOLLOWING INFORMATION:

GUARANTOR'S NAME _____ RELATIONSHIP _____

DOB ____/____/____ SSN_____–_____–_____ PHONE (_____)_____

ADDRESS _____ CITY_____ ST____ ZIP_____

PRIMARY INSURANCE INFORMATION

INS NAME _____ POLICY HOLDER _____ RELATIONSHIP _____

DOB ____/____/____ SSN_____–_____–_____ INS ID#_____ GRP # _____

SECONDARY INSURANCE INFORMATION

INS NAME _____ POLICY HOLDER _____ RELATIONSHIP _____

DOB ____/____/____ SSN_____–_____–_____ INS ID#_____ GRP # _____

RELEASE OF INFORMATION (VERBAL ONLY)

I authorize Lawrence Eye Care Associates, P.A. to communicate with _____ regarding my patient information.

PATIENT SIGNATURE _____ DATE____/____/____

LAWRENCE
EYE CARE
ASSOCIATES, P.A.

INSURANCE / PAYMENT AUTHORIZATION

PATIENT NAME _____ DOB _____/_____/_____

INSURANCE PAYMENT AUTHORIZATION

I authorize Lawrence Eye Care Associates, P.A. and its representatives to file my primary and secondary insurance and receive payment for services rendered. I also understand that I am responsible for 100% of any balance that is not paid or covered by my insurance.

PATIENT PAYMENT AUTHORIZATION

I understand that if I do not have insurance or if Lawrence Eye Care Associates, P.A. is not a provider with my insurance, I will be responsible for 100% of any balance that is not paid or covered by my insurance. Our practice is **NOT** contracted with Medicaid Insurance and we do **NOT** accept vision plans. The following plans will **NOT** be accepted: Amerigroup Kancare, United Healthcare Kancare, Sunflower Kancare, Straight Medicaid, All Vision Plans.

The Optical Shop will **ONLY** accept Traditional Medicare (Red/White/Blue Card) after cataract surgery; **NO** Medicare replacement plans will be accepted.

NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices for Lawrence Eye Care Associates, P.A. was made available to me on the date of this signed authorization.

BENEFICIARY OR AUTHORIZED SIGNATURE _____ DATE____/____/_____

Rev. 07/2016

LAWRENCE EYE CARE ASSOCIATES, P.A.

Patient Name _____ **Date of Birth** _____

Health Care Providers

Referring Doctor_____ Phone # ( )_____

Primary Care Doctor_____ Phone # ( )_____

Eye Care Doctor_____ Phone # ( )_____

Preferred Pharmacy & Location_____

Mail Order Pharmacy_____

Reason for Today's Visit

❑ blurry spot in vision	❑ discharge	❑ injury	❑ glaucoma evaluation	❑ red eye(s)
❑ blurry vision	❑ distorted vision	❑ flashes	❑ headaches	❑ burning sensation
❑ bump on eyelid(s)	❑ dizziness	❑ floaters	❑ itchy eyelid(s)	❑ pain in eye(s)
❑ loss of vision	❑ double vision	❑ dry eye(s)	❑ itchy eye(s)	❑ swelling
❑ crossed eyes	❑ droopy lid(s)	❑ glasses re-check	❑ glare	❑ other (please explain)
❑ wishing to be free of glasses or contacts	❑ foreign body sensation	❑ eyelashes turning in	❑ diabetic eye exam	_____

Severity:	❑ Minimal	❑ Mild	❑ Significant	❑ Moderate	❑ Severe
Location:	❑ Right eye	❑ Left eye	❑ Both eyes	❑ Other:	
Timing:	❑ None	❑ Intermittently	❑ Constantly	❑ Occasionally	❑ Once

This has been going on for: _____ Hours _____ Days _____ Weeks _____ Months

Additional Comments

_____

_____

_____

***Allergies:**

❑ None	❑ Eye drops _____
❑ Latex	❑ Medication _____
❑ Other:_____	❑ Food _____

Vision History

Previously Diagnosed
- ❑ None
- ❑ Cornea Disease
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Crossed or Lazy eye
- ❑ Dry Eye
- ❑ Macular Degeneration
- ❑ Diabetic Retinopathy
- ❑ Other: _____

Previous Eye Surgeries
(include year and surgeon)
- ❑ None
- ❑ Cataract
- ❑ Glaucoma
- ❑ Retina
- ❑ Laser
- ❑ Refractive
- ❑ Injury
- ❑ Other: _____

Current Eye Drops
Prescription & Over the Counter
- ❑ None
- ❑ Artificial Tears _____times a day
- ❑ Gel drops_____ times a day
- ❑ Ointment _____ times a day
- ❑ Other: _____

Current Eye Vitamins: _____
(list brand)

Medical History

Previously Diagnosed (Include Year)	**Past Surgeries** (include year)	**Current Medications** (include dosage and vitamins)
❑ None	❑ None	❑ None
❑ Diabetes _____	❑_____	❑_____
❑ Plaquenil Treatment _____	❑_____	❑_____
❑ Thyroid Problems _____	❑_____	❑_____
❑ Prostate Problems _____	❑_____	❑_____
❑ _____	❑_____	❑_____
❑_____	❑_____	❑_____
❑_____	❑_____	❑_____
❑_____	❑_____	❑_____
❑_____	❑_____	❑_____

Family History

Has anyone in your family (blood relatives) had any of the following?

❑ macular degeneration ❑ cancer ❑ heart disease ❑ glaucoma ❑ diabetes
❑ High blood pressure ❑ stroke ❑ kidney disease ❑ retinal disease ❑ cataracts
❑ crossed or lazy eye ❑ arthritis ❑ blindness ❑ TB ❑ Other: _____

Social History

Smoking
❑ Never smoked
❑ Current every day smoker
❑ Current some day smoker
❑ Former smoker

Alcohol
❑ Never
❑ Daily
❑ Occasionally
❑ Seldom

Drugs
❑ Never used
❑ Current every day user
❑ Current some day user
❑ Former user

Review of Systems

Eyes *
- Previous Surgery ☐ YES
- Contact Lens ☐ YES
- Pain ☐ YES
- Double Vision ☐ YES
- Glaucoma ☐ YES
- Cataracts ☐ YES
- Macular Degeneration ☐ YES
- Dry Eyes ☐ YES
- Flashes ☐ YES
- Floaters ☐ YES

Ear, Nose, and Throat *
- Hard of Hearing ☐ YES
- Ringing in Ears ☐ YES
- Vertigo ☐ YES

Cardiovascular *
- Chest Pain ☐ YES
- Dizziness ☐ YES
- Fainting Spells ☐ YES
- Shortness of Breath ☐ YES
- Irregular Heart Beat ☐ YES
- Difficulty Lying Flat ☐ YES
- High Blood Pressure ☐ YES
- High Cholesterol ☐ YES

Constitutional *
- Fatigue/Weakness ☐ YES
- Fever ☐ YES
- Weight Gain/Loss ☐ YES

Respiratory *
- Cough ☐ YES
- Congestion ☐ YES
- Wheezing ☐ YES
- Asthma ☐ YES
- COPD ☐ YES

Gastrointestinal *
- Heartburn ☐ YES
- Nausea/Vomiting ☐ YES
- Jaundice/Hepatitis ☐ YES

Genito-Urinary *
- Pain/Difficulty ☐ YES
- Blood in Urine ☐ YES
- History of Kidney Stones ☐ YES
- History of STD's ☐ YES

Psychiatric *
- Anxiety/Depression ☐ YES
- Mood Swings ☐ YES
- Difficulty Sleeping ☐ YES

Endocrine *
- Increased Thirst ☐ YES
- Increased Hunger ☐ YES
- Increased Urination ☐ YES
- Increased Sweating ☐ YES
- Fingernail Changes ☐ YES

Blood/Lymphnodes *
- Easy Bruising ☐ YES
- Gums Bleed Easily ☐ YES
- Prolonged Bleeding ☐ YES
- Heavy Aspirin Use ☐ YES

MusculoSkeletal *
- Stiffness ☐ YES
- Arthritis ☐ YES
- Joint Pain/Swelling ☐ YES

Skin *
- Rash/Sores ☐ YES
- Lesions ☐ YES
- Hives/Eczema ☐ YES

Neurological *
- Seizures ☐ YES
- Weakness/Paralysis ☐ YES
- Numbness ☐ YES
- Tremors ☐ YES
- Stroke/TIA ☐ YES

Immunologic *
- Hives ☐ YES
- Itching ☐ YES
- Runny Nose ☐ YES
- Sinus Pressure ☐ YES

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Patient Name:_____

This questionnaire must be completed by all Medicare patients. If any answer to questions 1a through 4 is yes, please complete the corresponding section of the "Other Insurance" form.

	YES	***NO***
1. Are you a Veteran?	___	___
a. Did the VA refer you here for treatment?	___	___
b. Do you have a VA "Fee Basis ID Card"?	___	___
2. Do you have a Federal Black Lung card?	___	___
3. Are you covered by an employer's health insurance plan through your own employment or that of a family member? (Not retiree coverage)	___	___
4. Is this a medical condition due to an accident?	___	___

a. ___Auto ___Work Related ___Injured at Home ___Other

_____ _____

Signature Date