



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.

PATIENT INFORMATION

FULL NAME _____ DOB ___/___/___ SSN ___-___-___

ADDRESS _____ CITY _____ ST ___ ZIP _____

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

GENDER: ___M ___F MARITAL STATUS _____ SPOUSE NAME _____

*EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE _____

*Emergency contact will be used for emergencies only and is **NOT** authorized for release of information.

RACE:

___ African American

___ Asian

___ White

___ Other _____

ETHNICITY:

___ Hispanic/Latino

___ Not Hispanic/Latino

___ Other _____

EMPLOYER _____ PHONE _____ OCCUPATION _____

PRIMARY INSURANCE

INS NAME _____ POLICY HOLDER _____ RELATIONSHIP _____

DOB ___/___/___ SSN ___-___-___ INS ID# _____ GRP # _____

SECONDARY INSURANCE

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.

IF THE PATIENT IS A DEPENDENT OR STUDENT, PLEASE PROVIDE THE FOLLOWING:

RESPONSIBLE PARTY NAME _____ RELATIONSHIP _____

DOB ___/___/___ SSN ___-___-___ PHONE (____) _____

ADDRESS _____ CITY _____ ST ___ ZIP _____

PATIENT SIGNATURE _____ DATE ___/___/___



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, Traditional Medicaid, All Vision Plans.

The Optical Shop will **ONLY** accept Traditional Medicare (Red/White/Blue Card) after cataract surgery.

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 ____/____/____

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

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

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

Respiratory *

- Cough YES
Congestion YES
Wheezing YES
Asthma YES
COPD YES

Blood/Lymphnodes *

- Easy Bruising YES
Gums Bleed Easily YES
Prolonged Bleeding YES
Heavy Aspirin Use YES

Gastrointestinal *

- Heartburn YES
Nausea/Vomiting YES
Jaundice/Hepatitis YES

MusculoSkeletal *

- Stiffness YES
Arthritis YES
Joint Pain/Swelling YES

Ear, Nose, and Throat *

- Hard of Hearing YES
Ringing in Ears YES
Vertigo YES

Genito-Urinary *

- Pain/Difficulty YES
Blood in Urine YES
History of Kidney Stones YES
History of STD's YES

Skin *

- Rash/Sores YES
Lesions YES
Hives/Eczema 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

Psychiatric *

- Anxiety/Depression YES
Mood Swings YES
Difficulty Sleeping YES

Neurological *

- Seizures YES
Weakness/Paralysis YES
Numbness YES
Tremors YES
Stroke/TIA YES

Constitutional *

- Fatigue/Weakness YES
Fever YES
Weight Gain/Loss YES

Endocrine *

- Increased Thirst YES
Increased Hunger YES
Increased Urination YES
Increased Sweating YES
Fingernail Changes YES

Immunologic *

- Hives YES
Itching YES
Runny Nose YES
Sinus Pressure YES

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Patient Name: _____ DOB: ____/____/____

Please respond to each of the following:

1. Are you receiving Black Lung Benefits? YES NO
2. Are the services to be paid by a government research program? YES NO
3. Are you entitled to benefits from the Department of Veteran Affairs? (VA) YES NO
4. Is your illness/injury due to any of the following: YES NO
Work Related Auto Accident Other _____
5. Are you covered under any insurance plan through your or your spouse's employer?
YES NO

Patient Signature

Date