*Paul M. Lampert, O.D.* *200 S. Jefferson* *Plainville KS 67663*

## PATIENT FORM

Name:

First MI Last Preferred Name

Date of Birth: SSN: Male/Female

Street & Mailing Address:

City/St/Zip:

Cell Phone: Home: Work:

Email:

Please mark if you agree to be contacted by: ❐ALL ❐Cell ❐Text ❐Email ❐Home ❐Work ❐Mail

Marital Status: Single Married Divorced Legally Separated Widowed

Language/Race/Ethnicity:

Employer: Occupation:

Right or Left Handed? R L

**Guarantor Information (Person responsible for payment)**

Name:

First MI Last Relationship

Date of Birth: SSN: Male/Female

Street & Mailing Address:

City/State/Zip:

Cell Phone: Home: Work:

**Primary Care Physician:** **Pharmacy:**

**Current Medications (Prescription and Over-The-Counter)** **Please include dosage**

Allergies to any of the following? ☐ None ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Latex ☐ Metal

☐ Other (please list)

**Major surgeries/injuries**

*(Continued on back )*

# PATIENT FORM



| | | |
|---|---|---|
| Date of Last Eye Exam: | | |
| Where? | | |
| Currently Wear Glasses? | | |
| Currently Wear Contacts? | | |
| Brand? | | |
| Reason for Today's Visit: | | |
| | | |
| | | |
| Are you pregnant or nursing? | yes | no |
| Do you smoke? | yes | no |
| ☐ Cigarettes | ☐ Cigars | ☐ Pipe |
| If no, have you ever smoked? | yes | no |
| Do you use smokeless tobacco? | yes | no |
| Do you drink alcohol? | yes | no |

Are you currently experiencing, of have experienced, any of the following?

**Check** all that apply.

| | | |
|---|---|---|
| ☐ | Blurry Vision | near or distance |
| ☐ | Burning | |
| ☐ | Discharge | |
| ☐ | Double Vision | |
| ☐ | Dryness | |
| ☐ | Excess Tearing/Watering | |
| ☐ | Eye Infection | |
| ☐ | Eye Pain or Soreness | |
| ☐ | Floaters or Spots | |
| ☐ | Halos | |
| ☐ | Headaches | |
| ☐ | Itching | |
| ☐ | Light Flashes | |
| ☐ | Light Sensitivity | |
| ☐ | Redness | |
| ☐ | Sandy or Gritty Feeling | |

Have **you** or a **family member** experienced, or been treated for, any of the following?

**Circle** all that apply

| | | | | Relationship |
|---|---|---|---|---|
| AIDS/HIV | yes | no | family | |
| Allergies | yes | no | family | |
| Arthritis | yes | no | family | |
| Asthma | yes | no | family | |
| Blood/Lymph Disorder | yes | no | family | |
| Cancer | yes | no | family | |
| Diabetes | yes | no | family | |
| Ears, Nose, Throat Condition | yes | no | family | |
| Gastrointestinal Condition | yes | no | family | |
| Heart Disease | yes | no | family | |
| High Blood Pressure | yes | no | family | |
| High Cholesterol | yes | no | family | |
| Kidney Disease | yes | no | family | |
| Lupus | yes | no | family | |
| Neurological Condition | yes | no | family | |
| Psychiatric Disorder | yes | no | family | |
| Seizures | yes | no | family | |
| Skin Condition | yes | no | family | |
| Stroke | yes | no | family | |
| Thyroid Dysfunction | yes | no | family | |

Have **you** or a **family member** experienced, or been treated for, any of the following?

**Circle** all that apply

| | | | | Relationship |
|---|---|---|---|---|
| Cataracts | yes | no | family | |
| Crossed Eye | yes | no | family | |
| Glaucoma | yes | no | family | |
| LASIK or RK | yes | no | family | |
| Lazy Eye | yes | no | family | |
| Macular Degeneration | yes | no | family | |
| Retinal Detachment | yes | no | family | |

Patient or Guardian Signature　　　　Date

Doctor Signature　　　　Date

# Paul M. Lampert, O.D., P. A.

***Family Eye Care*** Phone (785) 434-2074
200 S. Jefferson Fax (785)688-4045
Plainville, KS 67663 www.lamperteye.com


## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

- I have read, had explained to me, or was given the opportunity to read Paul M. Lampert, OD's Notice of Privacy Practice and agree to continue my care with Paul M. Lampert, OD under said terms.
- I have read or had explained to me Paul M. Lampert, OD's Notice of Privacy Practice for Health Information Exchange which includes, but not limited to: Kansas Health Information Network and RxNT.
- By my signature below, I authorize Paul M. Lampert and staff to communicate with me by mail, answering machine message, voicemail, texting, and/or email according to the information I have provided in my patient registration information.

## PAYMENT POLICY

**Insurance:** We are contracted with several insurance plans. If you are insured by a plan we are not contracted with, or have no insurance, payment in full is expected at each visit. If we are unable to verify your insurance coverage, payment in full will be requested and you will be reimbursed when payment is received.

**Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions regarding your coverage.

**Co-payments:** All co-payments must be paid at the time of service.

**Non-covered services:** Services deemed non-covered by your insurance will be your responsibility and must be paid at time of service.

**Proof of insurance:** You are responsible for providing us with your most recent insurance information. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for all services and/or products.

**Claims submission:** We will submit your claims and assist you in any way we reasonably can to ensure your claims are paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

**Nonpayment:** If your account is over 60 days past due, a 2% monthly interest charge will be applied. Your account will be turned over to collections for non-payment. Partial payments will not be accepted on services. Partial payments will be negotiated on product, but product will not be released until paid in full. A $35 fee will be charged for any returned checks.

- I authorize Paul M. Lampert and staff to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third-party payors, and/or other physicians or healthcare entities required to participate in my care.
- I have read, understand, and agree to the provisions of this payment policy.

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**Patient or Guardian** **Relationship** **Date**