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)

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
124 E. Wichita Ave
Russell, KS 67665
Phone (785) 483-2291
Fax (785)483-3636
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**