SPECIALTY Eyecare Group
a member of Vision Source

David L. Kading, OD, FAAO, FCLSA Kristi Kading, OD, FAAO, FCOVD Katherine Shen, OD Charissa Young, OD

Adult Patient Intake Form

Patient's Legal Name: ______________________ DOB: __________ Last 4 of SSN# ________ Sex: M /F

Address: ______________________City: __________State: _______ Zip: _________

Home Ph: ______________ Cell Ph: ______________ E-mail: ______________

Occupation/Grade: ______________ Employer/School: ______________

If married, Spouse's Name: ______________ Occupation: ______________

Preferred language: ______________Race:______________Ethnicity:______________

Do you have children? If yes, please fill in below:

Name: ______________ DOB: _________ Name: ______________ DOB: _________

Name: ______________ DOB: _________ Name: ______________DOB: _________

How did you find out about us? ______________Referred by: ______________

(If Provider) Office name: ______________Phone #:______________

Location of office: ______________

Insurance Verification and Privacy Statement:

Vision Ins Co. Name: ______________ Subscriber's Name: ______________

Relationship to subscriber: Self/Spouse/Child Subscriber's ID/SSN# ______________/__________DOB:__________

Medical Ins Co. Name: ______________ Subscriber's Name: ______________

Relationship to subscriber: Self/Spouse/Child Subscriber's ID #______________DOB: __________

MUST SIGN BOTH LINES BEFORE PROCEEDING TO APPOINTMENT

Authorization: I certify that I have read and answered the above information to the best of my ability. My signature below serves as a signature on file for billing and that I have been given an opportunity to review the HIPPA Privacy Act as it applies to my care with Specialty Eyecare Group.

Signature ______________________ **Date** ______________

Insurance Coverage

In order to serve you better; please provide your insurance card(s) so we may make copies

In signing this statement I agree to be financially responsible for all charges. I understand that my insurance is not a substitute for payment and it is my responsibility to pay, in advance, the deductible, the co-pay and any other balance not paid by my insurance company. **I also understand that verification of my benefits is not a guarantee of payment.** Most insurance policies pay only a portion of the total fees. If you have questions about your coverage, please contact your insurance company. All accounts over 60 days will receive an interest charge of 1.5% per month (or 18% per year) on all unpaid balances.

I have had my insurance explained to me and have had an opportunity to ask questions. I understand that I am responsible for charges for services and products that are not covered by my insurance plan.

Signature ______________________ **Date** ______________

Please review and complete:

Health History

Last Eye Exam On: ____________________ Doctor's Name: ______________________________Phone# ______________________

Medical Doctor: ______________________ Clinic: _____________________________________ Phone# ______________________

Other Doctor: ________________________ Clinic: _____________________________________ Phone# _____________________

Medications (Prescribed and OTC) ____

Allergies (Medications):____

Allergies (Seasonal/Other):____

Developmental Delays? ____

Therapy/Tutoring? _____________________________________ Provider: ____

Therapy/Tutoring? _____________________________________ Provider: ____

Personal Eye Health History								
	Y	N		Y	N		Y	N
Full time glasses wear			White appearance in pupil			Frequent loss of place		
Glasses wear for distance only			Squinting/eye rubbing/blinking			Omits/Inserts/re-reads' letters or words		
Glasses wear for near only			Headaches			Poor reading comprehension		
Soft contact lens wear			Red/Itchy eyes			Confuses similar looking words		
Rigid contact lens wear			Blurry/double vision			Reversals after 1st grade		
Strabismus surgery			Crossed or Lazy eye			Smart in everything but school		
*If yes, Right eye			Head tilting/closing eye			Fatigue/frustration with homework		
*If yes, Left eye			Difficulty copying from board			Fatigue/frustration with reading		
Previous eye injuries			Poor handwriting, misaligns numbers			Difficulties with reading		
*If yes, Right eye			Inconsistent/poor sports performance			Difficulties with spelling		
*If yes, Left eye			Holds books closely			Difficulties with math		
Any loss of vision			Avoidance of near work			Is your child meeting their potentials		

Previous head trauma/injury? If yes, when? _____________ Location (on head): ____

Sports/Hobbies/Activities: ____

What activities require protective eyewear? ____

Social History

Drinking: ***YES / NO*** Amount (Weekly): ____________ Tobacco Use: ***YES / NO*** Amount (Weekly):____________

Smoking Status: Currently / Former / Heavy / Light / Never

Personal Health History

Constitutional	Y	N	Cardiovascular CON.	Y	N	Musculo CON.	Y	N
Developmental Disabilities			Heart Disease			Muscular Dystrophy		
Cancer			Vascular Disease			Ankylosing Spondylitis		
Fatigue Syndrome			Congestive Heart Failure			Osteoporosis		
ENT	***Y***	***N***	***Respiratory***	***Y***	***N***	***Integumentary***	***Y***	***N***
Hearing Loss			Asthma			Eczema		
Sinusitis			Bronchitis/ Emphysema			Rosacea		
Dry Mouth			Chronic Obstruction			Psoriasis		
Laryngitis			Sleep Apnea			Herpes Simplex (cold sores)		
Neurological	***Y***	***N***	***Gastrointestinal***	***Y***	***N***	Herpes Zoster (shingles)		
Multiple Sclerosis			Crohn's Disease			***Endocrine***	***Y***	***N***
Epilepsy			Colitis			Type 1 Diabetes Mellitus		
Cerebral Palsy			Ulcer			Type 2 Diabetes Mellitus		
Tumor			Acid Reflux			Thyroid Dysfunction		
Stroke			Celiac Disease			Hormonal Dysfunction		
Migraine			***Genitourinary***	***Y***	***N***	***Hemotological/Lymphatic***	***Y***	***N***
Autism Spectrum Disorder			Kidney Disease			Anemia		
Psychological	***Y***	***N***	Prostate Disease/Cancer			Large-volume Blood Loss		
Depression			STD			Ulcer		
Attention Deficit			Benign Prostate Hypertrophy			Hypercholesteremia		
Anxiety Disorder			Pregnant/ Nursing			***Immune***	***Y***	***N***
Bipolar Disorder			***Musculo***	***Y***	***N***	Rheumatoid Arthrities		
Cardiovascular	***Y***	***N***	Arthritis: Osteo/ Rheumatoid			Lupus		
Hypertension			Fibromyalgia			Sjogren's Syndrome		
Stroke/CVA								

Other personal health history: ____

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Family Medical and Ocular History

Condition	Y	N	Mother	Father	Sister	Brother	Mat. G-mother	Mat. G-father	Pat. G-mother	Pat. G-father
Cancer:										
Diabetes Mellitus										
Diabetes Mellitus Type 1										
Diabetes Mellitus Type 2										
Hypertension										
Hyperthyroidism										
Hypothyroidism										
Thyroid Disorder										
Cataract										
Macular Degeneration										
Glaucoma										
Other:										