SUMMIT

EYE SURGEONS

Date: _____

Name:_____Age:_____DOB: _____

Address: _____

Home Phone: _____ Cell Phone:_____

Email: _____

Primary Insurance: _____

ID #:_____Group #: _____

Medical Claims Address: _____

Insured member name: _____DOB: _____

Secondary Insurance: _____

ID #:_____Group #: _____

Medical Claims Address: _____

Insured member name: _____DOB: _____

Emergency Contact | Medical Records Access

Name:_____Phone #: _____

Relationship:_____Access to medical records? ☐ Yes ☐ No

Who referred you to this office? _____

Race		**Ethnicity**
☐ White	☐ Black or African American	☐ Hispanic or Latino
☐ Hispanic	☐ Native Hawaiian orPacific Islander	☐ Non-Hispanic or Latino
		☐ Other: _____
☐ Asian	☐ American Indian orAlaskan Native	

NAME:_____ DATE:_____

DATE OF BIRTH:_____ AGE:_____ WEIGHT:_____ HEIGHT:_____

DENTURES: ☐ UPPER ☐ LOWER HEARING AIDS: ☐ RIGHT ☐ LEFT CONTACTS: ☐ RIGHT ☐ LEFT

☐ NO KNOWN MEDICATION ALLERGIES

MEDICATION ALLERGIES	REACTION

Are you sensitive to any of the following?

☐ Iodine
☐ Topical Injected IV
☐ Tape Reaction
☐ Latex

ANESTHESIA REACTIONS:

Have you had any complication related to anesthesia? ☐ Yes ☐ No ☐ General ☐ Local

Describe reaction:_____

Malignant Hyperthermia: ☐ Yes ☐ No

Family Member with Complications Related to Anesthesia: ☐ Yes ☐ No

Describe reaction:_____

MEDICAL HISTORY **PLEASE CHECK ALL THAT APPLY**

HEART AND VASCULAR

☐ Heart Attack(s) (Dates): _____
☐ Angina/Chest Pain
☐ Murmur
☐ Abnormal Rhythm
☐ AFIB
☐ High Blood Pressure
☐ Heart Failure
☐ Pacemaker
☐ Mitral Valve Prolapse
☐ High Cholesterol
☐ Other:_____

LUNGS

☐ Asthma/Wheezing
☐ Emphysema
☐ Bronchitis
☐ Chronic Cough
☐ TB (or Family History)
☐ Shortness of Breath
☐ Recent Cough/Cold
☐ Sleep Apnea
☐ Other: _____

GENITAL/URINARY

☐ Kidney or Renal
☐ Dialysis Schedule: _____
☐ Other:_____

GASTRO-INTESTINAL

☐ Liver Disease
☐ Jaundice
☐ Hiatal Hernia
☐ Reflux
☐ Inflammatory Bowels
☐ Other:_____

BLOOD AND COAGULATION

☐ Aids/HIV
☐ Hepatitis Type: _____
☐ Anemia
☐ Bruising
☐ Other:_____

NERVOUS SYSTEM

☐ Stroke
☐ Seizures/Epilepsy
☐ Head/Neck Injury
☐ Multiple Sclerosis
☐ Other: _____

ENDOCRINE

☐ Diabetes
☐ Type 1 ☐ Type 2
☐ Thyroid Disease
☐ Hypo ☐ Hyper. ☐ Hashimoto's
☐ Other:_____

MUSCULO-SKELETAL SYSTEM

☐ Chronic Back or Neck Trouble
☐ Arthritis
☐ Osteo ☐ Rheumatoid
☐ Other:_____

OTHER

☐ Hearing Loss: ☐ RT ☐ LT
☐ Cancer: Type _____
☐ Pregnant
☐ Other: _____

Do you smoke? ☐ Yes ☐ No	Do you drink alcohol? ☐ Yes ☐ No	Do you use recreational drugs? ☐ Yes ☐ No
Frequency:	Frequency:	Frequency:

_____

SIGNATURE OF PATIENT OR GUARDIAN DATE

MEDICATIONS: ☐ **I DO NOT TAKE ANY MEDICATIONS**

Please include all medications including over the counter. If you have a list please indicate on this form and provide to front desk.

MEDICATION			
NAME OF MEDICATION	DOSAGE	HOW OFTEN	REASON FOR USE

EYE MEDICATION			
NAME OF MEDICATION	DOSAGE	HOW OFTEN	REASON FOR USE

HAVE YOU TAKEN ANY BLOOD THINNER OR ASPIRIN IN THE LAST 3 MONTHS? ☐ YES ☐ NO

HAVE YOU TAKEN OR CURRENTLY TAKE FLOMAX, RAPAFLO OR ANY URINARY RETENTION MEDICATION? ☐ YES ☐ NO

SURGICAL HISTORY ☐ **NONE**	
DATE	PROCEDURE

EYE SURGICAL HISTORY: ☐ **NONE**	
DATE	PROCEDURE

EYE HISTORY

DO YOU WEAR PRISM IN GLASSES FOR DOUBLE VISION? ☐ YES ☐ NO

HAVE YOU OR ANY MEMBER OF YOUR FAMILY BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

M=Mother F=Father S=Sibling GP=Grandparent

	SELF	FAMILY		SELF
CATARACTS			CORNEAL DYSTROPHY	
GLAUCOMA			DRY EYE	
KERATACONUS			CONJUNCTIVITIS (PINK EYE)	
MACULAR DEGENERATION			INJURY	
RETINAL DETACHMENT			LAZY/CROSSED EYE	
OTHER:				

SIGNATURE OF PATIENT OR GUARDIAN DATE

SUMMIT

EYE SURGEONS

AUTHORIZATION AND CONSENT FOR TREATMENT

_____

Patient Name (Printed)

I request that payment of benefits be made on my behalf (on assigned claims) to Summit Eye Surgeons for any services furnished to me by physicians in the aforementioned entity. I further agree that I am responsible for payment of charges incurred by me that are outside of the scope of my insurance coverage or for which my insurance company has paid me. If I have had previous refractive surgery, I understand that this may affect my insurance coverage and I could be responsible for the payment.

I hereby authorize Summit Eye Surgeons to release information acquired during the course of my examination or treatment to my referring physician or to an appropriate insurance carrier. If a Medicare patient, I further authorize release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services.

I authorize Summit Eye Surgeons to use eScript to retrieve my medication history. I authorize Summit Eye Surgeons to leave reminder messages on my answering devices for appointments.

I consent to receive medical care by Summit Eye Surgeons and its affiliates.

I hereby authorize medical treatment by the physician, the clinical staff and technical employees assigned to my care. I authorize my treating providers to order any ancillary services deemed necessary for my care and treatment. I understand that I have the right and the opportunity to discuss alternative plans of treatment with my physician or other healthcare provider and to ask and have answered to my satisfaction any questions or concerns.

_____ _____

Date **Signature**

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EYE SURGEONS

Acknowledgement of Receipt of Privacy Notice

Original to be maintained in patient's permanent medical record

I acknowledge that I have received a copy of the office's Notice of Privacy Practices

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed Name if signed on behalf of the patient. Relationship to patient

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EYE SURGEONS

Patient Pharmacy Information

Patient Name: _____ Date: _____

Local Pharmacy Information

Pharmacy Name: _____

Pharmacy *street* Address: _____

_____

Pharmacy Phone Number: _____

Mail-In Pharmacy Information

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Fax Number: _____

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Have you received a Flu Vaccine this year?

☐ YES

☐ NO

Have you received a Pneumonia Vaccine this year?

☐ YES

☐ NO