

J. Kent Nickell, O.D.
Randy Steele, O.D.

The Kentucky Eye Institute
587 MAIN STREET
WEST LIBERTY, KENTUCKY 41472

Patient Information

Patient Name: _____

Date of Birth: _____ Patient Social Security #: _____

Address: _____

Phone: Home _____ Work _____ Ext _____

If patient is a minor Parent/Guardian Name: _____

Marital status: Single Married Widowed Divorced

Occupation: (if retired, state Retired and what occupation was) _____

Please list any insurance we can bill for the services we perform, including medical insurance:

1. _____ 2. _____

Please list any medicine you are currently taking. If you have a list we will be happy to make a copy for your records: _____

Please list any medicine to which you are allergic: _____

Please circle yes (Y) or no (N) to any of the following eye problems you have had in the past:

Y / N Glaucoma Y / N Cataracts Y / N Retinal Detachment Y / N Macular Degeneration
Y / N Iritis Y / N Dry Eyes Y / N Allergies Y / N Episodes of double vision
Y / N Periods of vision loss Y / N Eye injuries Other _____

Please circle yes or no to any of the following health conditions you may have:

Y / N Heart Disease Y / N High Blood Pressure Y / N Diabetes Y / N High Cholesterol
Y / N Arthritis Y / N Muscle Disease Y / N Bone Disease Y / N Skin Disease
Y / N Histoplasmosis Y / N Emphysema Y / N Asthma Y / N Digestive Disorders
Y / N Headaches Y / N Migraine Headaches Y / N Shingles Y / N Cancer
Y / N Nerve Disorders Y / N Depression Y / N Anxiety Y / N AIDS
Y / N Sexually Transmitted Disease Y / N Are you pregnant Y / N Do you smoke Y / N Do you drink alcohol

Do you have a family history of any of following conditions:

Y / N Glaucoma Y / N Retinal Pigmentosa Y / N Macular Degeneration Y / N Blindness
Y / N Diabetes Y / N High Blood Pressure Y / N Heart Disease Y / N Cancer

Insurance Authorization: I request payment of all authorized benefits be made on my behalf to KEI for any services I receive from any KEI doctor. I authorize any holder of medical information about me to release information as needed to determine these benefits or the benefits for related services to my insurance company(ies) and their agent(s), including the Centers for Medicare and Medicaid Services (CMS) if I have Medicare/Medicaid coverage. I understand that I am responsible for all deductibles, co-pays, non-covered services, and the 20 % Medicare does not pay (if applicable).

Patient/Responsible Party Signature

Date

KENTUCKY EYE INSTITUTE CONSENT FOR PATIENT CONTACT

From time to time, it may be necessary for Kentucky Eye Institute to contact you concerning a variety of issues that pertain to your medical care. While the following list is not all-inclusive, we might need to contact you to:

- Make an appointment
- Cancel an appointment
- Inform you that your glasses or contact lenses are ready to be picked up
- Discuss your medical care and treatment
- Etc.

To assist you with your needs and to address the patient privacy issues described in the Health Insurance Portability and Accountability Act of 1996, we need you to specify the alternative ways we may contact you in the event we cannot reach you personally.

You may contact me by: (please check any box(es) that apply)

- Leaving a message on my home answering machine
- Leaving a message on my work answering machine
- E-mailing me at home _____
- E-mailing me at work _____
- Leaving a message with anyone who answers my telephone at home
- Leaving a message with anyone who answers my telephone at work
- U.S. mail
- Other (specify): _____

In the event you cannot contact me personally, you may discuss my care with any of the following individuals:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

No one

I give my consent for any representative of KEI to contact me regarding my care using the means I have indicated by the checked boxes above. Further, I give my permission to discuss my care with the individuals whose names are listed.

Patient's Signature

Date