



Patient Information

Date _____

Legal Name:

Dr/Mr/Mrs/Ms/Miss	First	Middle	Last	Suffix
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Nickname _____ Date of Birth _____ SS# _____

Street Address	City	State	Zip
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Home Phone	Work Phone	Other/Cell Phone
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Email address

May we contact you by email? Yes or No (please circle) Sex: M or F (please circle)

Employer	Occupation/ Job Title
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Emergency Contact	Emergency Phone
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Primary Care Physician _____

Primary Care Physician Phone _____

Were you referred by a medical doctor? Yes or No (please circle)

Were you referred by an eye doctor? Yes or No (please circle)

Who may we thank for referring you to our practice? Please provide their address if possible.

Durrie Vision, PA
8300 College Blvd – Suite 201 - Overland Park KS 66210
Phone - (913) 491-3330 Fax - (913) 491-9650

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I have been informed of the Privacy Practices and Patient Bill of Rights and have received a copy.

Signature of Patient or Personal Representative

Date

Are you eligible for Medicare coverage? Yes or No (please circle)

Are you covered by Medicare? Yes or No (please circle)

Patient Agreement

I understand that payment is due at the time of service. I certify that the information provided on all forms is correct. I authorize the release of medical information to Durrie Vision. I authorize my physician to prescribe medication and to give me reasonable and proper medical care by today's standards. This agreement is in effect until revoked in writing by the patient.

Signature of Patient or Personal Representative

Date

Health Insurance Portability and Accountability Act Waiver

Because Durrie Vision is bound by the rules of the Health Insurance Portability and Accountability Act (HIPAA), we are unable to provide any information to any person other than you without your consent. This includes information about your account, appointment times, prescriptions or any information contained in your records with us. **Please list any persons or agencies that we have your permission to release your information to.**

(This information can be amended by you as needed.)

Messages:

I give my consent to the physicians, staff, or prerecorded message systems at Durrie Vision to leave messages or discuss scheduling, treatment, surgery, or other information regarding my care as follows:

- | Yes | No |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> On answering machine or voice mail at home |
| <input type="checkbox"/> | <input type="checkbox"/> On answering machine or voice mail at work |
| <input type="checkbox"/> | <input type="checkbox"/> Cell Phone |
| <input type="checkbox"/> | <input type="checkbox"/> Text Messaging (Cell phone number on file) |
| <input type="checkbox"/> | <input type="checkbox"/> Email (email address on file) |

Signature of Patient or Personal Representative

Date

Health History

Name: _____

Date: _____

Medication History

Please list all medications you are currently taking:

Do you have a history of taking Flomax or similar medication for prostate issues?

Yes or No (please circle) _____

Ocular History

Have you ever been diagnosed with any of the following eye problems? Yes or No, If so, please include which eye, using R for right eye, L for left eye, and B for both eyes.

Amblyopia/Lazy Eye Dry Eye Iritis
 Cataracts Fuch's Dystrophy Keratoconus
 Corneal Scar Glaucoma Macular Degeneration
 Diabetic Retinopathy Injury/Trauma Retinal Detachment/Tear
 Other _____

Have you had any eye surgeries? Yes or No (please circle)

Surgery	Eye	Date	Doctor	Doctor's City/State
Cataract				
CK				
Corneal Transplant				
Lasik				
Lid Surgery				
LTK				
PRK				
RK				
Retinal Detachment and/or Repair				
Strabismus/Muscle Surgery				
Yag Laser				
Other				

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Personal History

Have you ever been treated for any of the following medical conditions?

- | | | |
|---|--|--|
| <input type="checkbox"/> Anesthesia Complications | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Paraplegia |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Quadriplegia |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Hepatitis A or B or C | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes Simplex | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cervical Fracture | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid Dysfunction |
| <input type="checkbox"/> Diabetes (insulin dependent) | <input type="checkbox"/> Lupus | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diabetes (non-insulin dependent) | <input type="checkbox"/> Migraines | |

Do you currently have any of the following?

- | | | |
|--|---|------------------------------------|
| <input type="checkbox"/> Cochlear Implants | <input type="checkbox"/> Internal Defibrillator | <input type="checkbox"/> Pacemaker |
|--|---|------------------------------------|

Are you currently pregnant? Yes or No (please Circle)

Are you currently breastfeeding? Yes or No (please circle)

In the last 5 years, have you had any surgeries? Yes or No (please circle)

If so, please list and include date of surgery _____

Patient Allergies

Please list all medications you are allergic to:

Are you allergic to:

- | | | |
|-------------------------------|--------------------------------|--|
| <input type="checkbox"/> Tape | <input type="checkbox"/> Latex | <input type="checkbox"/> Iodine/Betadine |
|-------------------------------|--------------------------------|--|

Family Medical History

Do any of your grandparents, parents, or siblings have any of the following?

- | | | |
|------------------------------------|---|--|
| <input type="checkbox"/> Adopted | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Retinal Detachment or Disease |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Macular Degeneration | |

Social History

Do you drink? Yes or No (please circle) How Often? _____

Do you smoke? Yes or No (please circle) How Often? _____