DURRIE VISION

Patient Information

Date _____

Legal Name:

_____

Dr/Mr/Mrs/Ms/Miss First Middle Last Suffix

Nickname _____ Date of Birth _____ SS# _____

_____

Street Address City State Zip

_____ _____ _____

Home Phone Work Phone Other/Cell Phone

_____

Email address

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

_____ _____

Employer Occupation/ Job Title

_____ _____

Emergency Contact Emergency Phone

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	
☐	☐	On answering machine or voice mail at home
☐	☐	On answering machine or voice mail at work
☐	☐	Cell Phone
☐	☐	Text Messaging (Cell phone number on file)
☐	☐	Email (email address on file)

_____ _____

Signature of Patient or Personal Representative Date

DURRIE VISION

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?

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

Do you currently have any of the following?

__ Cochlear Implants
__ Internal Defibrillator
__ 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:

_____ Tape _____ Latex _____ Iodine/Betadine

Family Medical History

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

__ Adopted
__ Blindness
__ Cataracts
__ Diabetes
__ Glaucoma
__ Heart Disease
__ High Blood Pressure
__ Macular Degeneration
__ Retinal Detachment or Disease
__ Stroke
__ Other _____

Social History

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

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