**Kentucky Eye Center, P.S.C.**
1401 Harrodsburg Road, Suite B290
Lexington, KY 40504
(859) 277-2692

**PATIENT REGISTRATION FORM**

**Today's Date**_____ **Account Number**_____

**PATIENT'S NAME**_____ SEX: M☐ or F☐ DATE OF BIRTH: _____ AGE_____

SOCIAL SECURITY #_____ MARITAL STATUS: (◯)Single (◯)Married (◯)Separated (◯)Divorced (◯)Widowed

ADDRESS_____

CITY _____ STATE_____ ZIP_____ E-MAIL ADDRESS_____

HOME PHONE_____ CELL PHONE_____

EMPLOYER_____ JOB TITLE_____

EMERGENCY CONTACT_____ EMERGENCY CONTACT PHONE_____

PREFERRED PHARMACY _____ ADDRESS_____

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**Who suggested you visit our office?** ( ◯ ) Physician ( ◯ ) Family ( ◯ ) Friend ( ◯ ) Internet ( ◯ ) Other

_____ _____
Name Address

Primary Care Physician, if not listed above_____

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**Person Responsible for Bill** If Patient, check here.: ☐ If other than Patient, Relationship to Patient:_____
*Complete the following, if other than Patient:*

NAME_____ PHONE_____

SOCIAL SECURITY # _____ DATE OF BIRTH_____

EMPLOYER_____

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**INSURANCE** - Please provide information regarding all your insurance, including medical and routine vision coverage. Copies will be made of your cards.

Primary Insurance _____ Policy #: _____
Secondary Insurance _____ Policy #: _____
Vision Insurance _____ Policy #: _____

*Your signature is required below if our office will be billing your insurance directly.

**Insurance: Subscriber Name:**_____ **Subscriber Date of Birth:**_____
I hereby authorize Kentucky Eye Center to release any information regarding services rendered by them and allow a photocopy of my signature to be used to file insurance. I hereby authorize and direct my insurer to issue payment check(s) for benefits due for me for the services rendered by Kentucky Eye Center to be made directly to them. Regardless of my insurance benefits, if any, I understand that I am financially responsible for all services rendered including to but not limited to copays, deductibles, coinsurance and any non-covered services.

_____ _____
Patient/Responsible Party Signature Date

**MEDICAL HISTORY**

*Please check all that apply:*

- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ BPH (Enlarged Prostate)
- ☐ Cancer: Type_____
- ☐ COPD
- ☐ Heart Disease
- ☐ Depression
- ☐ Diabetes: Date discovered_____
  Doctor_____
- ☐ End Stage Renal Disease
- ☐ GERD (Acid Reflux)
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other _____

**OCULAR HISTORY**

*Please check all that apply:*

- ☐ Allergic Conjunctivitis (Pink Eye)
- ☐ Blepharitis
- ☐ Cataract: R☐ L☐
- ☐ Contact Lenses
- ☐ Corneal Dystrophy: R☐ L☐
- ☐ Diabetic Retinopathy: R☐ L☐
- ☐ Dry Eyes
- ☐ Glasses
- ☐ Glaucoma: R☐ L☐
- ☐ Macular Degeneration: R☐ L☐
- ☐ Narrow Angles: R☐ L☐
- ☐ Ocular Hypertension: R☐ L☐
- ☐ Ocular Migraine
- ☐ Retinal Tear: R☐ L☐
- ☐ Strabismus
- ☐ Vitreous Floaters: R☐ L☐
- ☐ Other _____

**BODILY SURGERY** **DATE**

1. _____
2. _____
3. _____
4. _____
5. _____

**OCULAR SURGERY** **DATE**

1. _____
2. _____
3. _____
4. _____
5. _____

**MISC. HEALTH INFORMATION**

1. _____
2. _____
3. _____

*** * * * *COMPLETE BOTH SIDES* * * * ***

**FAMILY HISTORY**
*Please check all that apply:*

- ☐ Blindness
- ☐ Cancer: Type_____
- ☐ Cataracts
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Macular Degeneration
- ☐ Migraines
- ☐ Retinal Disease
- ☐ Stroke
- ☐ Other _____

**MEDICATIONS** *Provide a list to the front desk or fill in below:*

| | | | |
|---|---|---|---|
| | | | |
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| | | | |

**DRUG ALLERGIES**

| | | | |
|---|---|---|---|
| | | | |
| | | | |

**SOCIAL/PHYSCHOSOCIAL**

Alcohol Use: ◯Never ◯Occasionally ◯Frequently ◯Everyday

Tobacco Use: ◯Current Smoker ◯Former Smoker ◯Never Smoked ◯E-Cigarettes

**RACE**

- ◯ White
- ◯ Black or African American
- ◯ Asian
- ◯ American Indian
- ◯ Pacific Islander
- ◯ Other _____

**Race/Ethnicity patient information is a Medicare requirement for electronic health records.*

**ETHNICITY**

- ◯ Hispanic or Latino
- ◯ Not Hispanic or Latino

Patient Signature: _____ Date: _____

*** * * * *COMPLETE BOTH SIDES* * * * ***

# Review of Systems

Check all that apply:

- ☐ Blurry vision
- ☐ Eye pain
- ☐ Tearing
- ☐ Eye redness
- ☐ Rashes
- ☐ Sores
- ☐ Lumps
- ☐ Hearing loss
- ☐ Ringing
- ☐ Aching
- ☐ Nosebleed
- ☐ Sinus infection
- ☐ Cough
- ☐ Wheezing
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Heart trouble
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Swelling of ankles
- ☐ Diabetes
- ☐ Trouble swallowing
- ☐ Heartburn
- ☐ Abdominal pain
- ☐ Abnormal appetite
- ☐ Excessive thirst
- ☐ Change in bowels
- ☐ Liver trouble
- ☐ Gall bladder trouble
- ☐ Constipation
- ☐ Frequent urination
- ☐ Burning on urination
- ☐ Incontinence
- ☐ Urinary stones
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Arthritis
- ☐ Headache
- ☐ Fainting
- ☐ Stroke
- ☐ Seizures
- ☐ Numbness
- ☐ Tremors
- ☐ Thyroid trouble
- ☐ Bleeding
- ☐ Hay fever
- ☐ Seasonal allergies
- ☐ Food allergies
- ☐ Memory problems
- ☐ Anxiety
- ☐ Depression

Patient Signature: _____ Date: _____

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# Consent for Disclosure of Records

I hereby consent to Kentucky Eye Center, P.S.C. using or disclosing my protected health information for the purposes of providing treatment to me, obtaining payments for health care services rendered to me or to carry out the practice's healthcare operations. I also consent to the practice using or disclosing my protected health information for treatment activities provided by another healthcare provider, as well as the payment activities conducted by another healthcare provider or entity. I further consent to the disclosure of my protected health information in order for another provider or healthcare entity to conduct healthcare operations including quality assessment and reviewing the competence of healthcare professionals.

I further acknowledge the practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

_____
Signature of Patient or Personal Representative of patient

_____
Name of Patient or Personal Representative of patient

_____
Date

I hereby authorize the release of my health information to the following individuals:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____