Noyce Family Eye Care PA

8801 W. 95th Street, Overland Park, Kansas 66212
Office: (913) 499-8404 Fax: (913) 766-1430

Date_______________ How did you hear about our practice _______________________

Patient Information

First Name ______________________________ Last Name ______________________________ MI _______

Address ____

City________________________________ State____________________ Zip ________________________

Home Phone ____________________ Work Phone ____________________ Cell Phone ____________________

Date of Birth_______________ Age________ Gender M / F Child Y / N SS# ________________________

Occupation___________________________ Email____

Responsible party (if other than above)_________________________ Relationship ____________________

Insurance

Medical: ________________________Member ID#_____________________ Group#_________________

Vision: _________________________Member ID#_____________________ Group#_________________

(if same as above print SAME)
Primary Card Holder: First Name ________________________ Last Name ______________________ MI _____

Address____

City______________________________ State_____________________________ Zip Code ______________

Home Phone ____________________ Work Phone ____________________ Cell Phone ____________________

Date of Birth ____________________ Age __________ Gender M / F SS# ____________________________

Occupation___________________________ Email____

Medical Information and Family History

	Self	Relative	Who		Self	Relative	Who
Gastrointestinal	Y / N	Y / N	__________	Nervous	Y / N	Y / N	__________
Ears/Nose/Throat	Y / N	Y / N	__________	Urinary	Y / N	Y / N	__________
Cardiovascular	Y / N	Y / N	__________	Muscles/Bones	Y / N	Y / N	__________
Allergic/Immunologic	Y / N	Y / N	__________	Respiratory	Y / N	Y / N	__________
Integumentary (skin)	Y / N	Y / N	__________	Headaches	Y / N	Y / N	__________
High blood pressure	Y / N	Y / N	__________	Eyes	Y / N	Y / N	__________
Endocrine (glands)	Y / N	Y / N	__________	Blood/Lymph	Y / N	Y / N	__________
Mental	Y / N	Y / N	__________	Diabetes	Y / N	Y / N	__________
Macular Degeneration	Y / N	Y / N	__________	Glaucoma	Y / N	Y / N	__________
Retinal Detachment	Y / N	Y / N	__________	Cataracts	Y / N	Y / N	__________

Current Medications: For what reason?

___________________________________ ____

Allergies to medication? Y / N Which?____

Have you had any operations? Y /N What kind?______________________________ When? ___________

Name of family doctor and/or primary care physician ______________________________
Date of last visit ______________ Date your blood pressure was last checked ______________

Personal Eye Information

Do you wear glasses? Y / N Do you wear contact lenses? Y / N Type______________________________

Date of Last Eye Exam? ___________ Name of last Optometrist/Ophthalmologist ______________________

Have you had any eye operations? Y / N Type____________________________ Date_____________

Have you had an eye injury? Y / N Type________________________________ Date_____________

Lifestyle

Do you drive? Y / N Does night driving bother you? Y / N

Do you use a computer? Y / N How often? ___________ (hours per day)

(The following information is kept strictly confidential. If you prefer you may discuss this directly with the doctor)

Do you consume alcohol? Y / N

Do you use tobacco products? Y / N

Do you use illicit drugs? Y / N

Financial Responsibility/HIPAA Privacy Authorization for Use and Disclosure

By signing this authorization you acknowledge and agree that Noyce Family Eye Care PA (NFEC) may use or disclose treatment, payment and related healthcare operations, oral, written or recorded for the purpose(s) of providing you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. You have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand NFEC'S HIPAA Privacy Notice (effective date February 1st, 2012) containing a complete description of your rights, and the permitted uses and disclosures under HIPAA.

Your signature below also forms a binding agreement between Noyce Family Eye Care PA and the patient who is receiving medical services or the Responsible Party for minors (patients under 18 years old). ***All charges for services rendered are due and payable at the time of service.*** We have contracts with many insurance companies and we will bill them as a service to you. As the Responsible Party, you are responsible for payment if your insurance company denies payment for any reason. If a payment is made on an account by check and the check is returned due to Non-Sufficient Funds (NSF) or Account Closed (AC), you will be responsible for the original check amount as well as a $25 Service Charge. A letter will be sent to notify you of the returned check. If a response is not made within 15 days from the date of said letter the account may be turned over to our collection agency.

Signature of Patient or Parent/Guardian______________________________________ Date____________

Signature of Witness ____ Date____________