KAY • TABAS • NIKNAM • DIDOMENICO

# OPHTHALMOLOGY ASSOCIATES

Today's Date _____/_____/_____

## PATIENT INFORMATION (Please Print)

| Patient's Last Name | First | Middle | ❑ Dr. ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. | Marital Status (Circle One) Single / Mar / Div / Sep / Wid |
|---|---|---|---|---|

| Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former Name) | Birth Date / / | Age | Sex ❑ M ❑ F |
|---|---|---|---|---|---|

| Street Address | City | State | ZIP Code | Social Security | Home Phone No. & Cell Number ( ) ( ) CELL |
|---|---|---|---|---|---|

| P.O. Box | City | State | ZIP Code |
|---|---|---|---|

| E-MAIL ADDRESS (to receive our informative quarterly newsletter): | OCCUPATION: | EMPLOYER: | Employer Phone No. ( ) |
|---|---|---|---|

Chose KTOA Because/Referred to KTOA by (Please check one box) ❑ Dr. _____ ❑ Insurance Plan ❑ Website
❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

Other Family Members Seen Here _____

Primary Physicians Name: _____ Primary Physicians Phone Number: _____
Address: _____

## INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

| Person Responsible for Bill | Birth Date / / | Address (if different) | Home Phone No. |
|---|---|---|---|
| Is this person a patient here? | ❑ Yes ❑ No | | ( ) |

| Occupation | Employer | Employer Address | Employer Phone No. |
|---|---|---|---|

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance _____

| Subscriber's Name | Subscriber's S.S. # | Birth Date / / | Group # | Policy # | Co-Payment $ |
|---|---|---|---|---|---|

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

| Name of Secondary Insurance (if applicable) | Subscriber's Name | Group # | Policy # |
|---|---|---|---|

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

## IN CASE OF EMERGENCY

| Name of Local Friend or Relative (not living at same address) | Relationship to Patient | Home Phone No. ( ) | Work Phone No. ( ) |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Kay & Tabas Ophthalmology Associates or insurance company to release any information required to process my claims.

X _____
PATIENT/GUARDIAN SIGNATURE DATE

PATIENT'S NAME: _____ DATE OF BIRTH:_____

Please list any past and present eye problems. (Describe present symptoms; list any previous eye surgery with approximate dates.)

List all **EYE** medications and describe how they are being used and in which eye:

Do you smoke? _____ If so, how much? _____
Do you drink? _____ If so, how much? _____

List any family history of eye problems (i.e. glaucoma, retinal problems, cataracts, eye muscle problems, etc.)

Do you wear glasses? _____ How long have you worn glasses? _____

How old is your present prescription? _____

Do you wear contact lenses? _____ How long have you worn contact lenses? _____

What type of lenses do you wear? _____ How old is your present prescription? _____

Are you **ALLERGIC** to any drugs or medications? (Please list names)

Do you have any of the following conditions: (all information will be confidential)

DIABETES/HOW LONG? _____HEART PROB.? _____ HIGH BLOOD PRESSURE? _____
HIV POSITIVE? _____ Any other medical conditions? _____

| **REVIEW OF SYSTEMS – Please circle if you have any of these problems.** | |
|---|---|
| **GI** | **Nausea/ vomiting/ diarrhea/ weight loss/ appetite loss/ blood in stools** |
| **HEART/LUNG** | **Asthma/ chest pain/ shortness of breath/ cough/ irregular heart beat** |
| **GU** | **Pain on urination/ blood in urine/ incontinence/ discharge** |
| **HEENT** | **Headaches/ hearing loss/ sore throat/ voice change** |
| **SKELETAL** | **Joint pain/ muscle pain/ back pain/ range of motion restriction** |
| **SKIN** | **Rashes/ bruises/ new skin lesions** |
| **NEURO** | **Headache/ blackouts/ seizures/ dizziness/ numbness or tingling** |
| **ENDOCRINE** | **Thyroid/ excessive thirst or urination/ hot or cold intolerance** |

List any medications that you may be taking (other than eye medications):
_____

List any major surgery (other than eye surgery and include approximate dates):
_____