*London Eye Care (A Kentucky Eye Institute Facility) New Patient Registration Form*

Dr. _____ Date _____ Time _____Person#_____

PATIENT INFORMATION:

Name _____ Sex: M ☐ F ☐ Date of Birth _____/_____/_____

Address _____ Social Security # _____
Street City State Zip

Email_____ Home # _____ Cell # _____

Reason for Visit _____

Were you referred to our office by another doctor / provider? Yes ☐ No ☐ - If so, who? _____

Family doctor _____ Preferred Pharmacy_____ Location_____

PRIMARY INSURANCE INFORMATION:

Insurance Company Name_____ Member ID_____

Name of Subscriber _____ Relationship to Patient _____

Date of Birth _____/_____/_____ Social Security # _____-_____-_____ Employed? Yes ☐ No ☐

Employer _____

---

**INSURANCE AUTHORIZATION:** I request payment of all authorized benefits be made on my behalf to LEC/KEI for any services I receive from any KEI doctor. I authorize any holder of medical information about me to release information as needed to determine these benefits or the benefits for related services to my insurance company(ies) and their agent(s), including the Centers for Medicare and Medicaid Services (CMS) if I have Medicare/Medicaid coverage. I understand that I am responsible for all deductibles, co-pays, non-covered services, and the 20% Medicare does not pay (if applicable).

_____ _____
Patient/Reposnisble Party Signature Date

---

**PAST DUE ACCOUNTS:** I understand that interest will be charged on accounts that are 90 days or more past due. If LEC/KEI turns my account over to a collection agency, I understand that the collection agency will add interest of 1 1/2 % per month (18% per year) to any unpaid balances. Except for emergencies, if my account has been turned over for collection, I may only schedule future LEC/KEI appointments if I pay: for future services in advance, unpaid balances, and collection agency commission and/or legal fees paid by LEC/KEI to collect my delinquent account.

_____ _____
Patient/Reposnisble Party Signature Date

---

**I ackowledge receipt of the document titled "Notice of Privacy Practices"**

_____ _____
Patient/Reponsible Party Signature Date

---

**If you are covered by Medicare and a Group Health Insurance, please complete this section.**
Are you or your spouse still employed? Yes☐ No☐ If yes, does the employer have (check one) 20 – 99 employees☐ 100 or more employees☐
Are you entitled to Medicare because of a disability? Yes☐ No☐ Are you entitled to Medicare due to renal disease? Yes☐ No☐

*London Eye Care (KEI) complies with the FTC "Red Flag" identity theft regulations*
☐ Appointment in Computer ☐ Information in Computer ☐ ROS & New Patient Sheets Mailed
*****COMPLETE BOTH SIDES*****

# *London Eye Care (KEI) Consent for Patient Contact*

From time to time, it may be necessary for London Eye Care (KEI) to contact you concerning a variety of issues that pertain to your medical care. While the following list is not all-inclusive, we might need to contact you to:

- Make an appointment
- Cancel an appointment
- Inform you that your glasses or contact lenses are ready to be picked up
- Discuss your medical care and treatment

To assist you with your needs and to address the patient privacy issues described in the Health Insurance Portability and Accountability Act of 1996, we need you to specify the alternative ways we may contact you in the event we cannot reach you personally.

**You may contact me by: (please check any box(es) that apply)**

- ☐ Leaving a message on my home answering machine
- ☐ Leaving a message on my work answering machine
- ☐ Emailing _____
- ☐ Leaving a message with anyone who answers my telephone at home
- ☐ Leaving a message with anyone who answers my telephone at work
- ☐ U.S. mail
- ☐ Text message (standard message and data rates may apply)
- ☐ Other (specify) _____

In the event you cannot contact me personally, you may discuss my care with any of the following individuals (**please include power of attorney if applicable**). Check here if none

Name_____ Relationship _____ Phone_____

Name_____ Relationship _____ Phone_____

Name_____ Relationship _____ Phone_____

I give my consent for any representative of LEC/KEI to contact me regarding my care using the means I have indicated by the checked boxes above. Further, I give my permission to discuss my care with the individuals whose names are listed.

_____ _____

Patient/Reponsible Party Signature Date

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

# Review of Systems

Please check all that apply:

- ☐ Poor vision
- ☐ Eye pain
- ☐ Tearing
- ☐ Redness
- ☐ Jaw pain
- ☐ Scalp tenderness
- ☐ Amaurosis fugax (sudden temporary loss of vision)
- ☐ Loss of vision
- ☐ High blood pressure
- ☐ Congestion
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Arthritis
- ☐ Diabetes
- ☐ Allergies
- ☐ Fever
- ☐ Chills
- ☐ Weight loss
- ☐ Stuffy nose
- ☐ Earache
- ☐ Cough
- ☐ Dry mouth
- ☐ Rapid heartbeat
- ☐ Upset stomach
- ☐ Diarrhea
- ☐ Constipation
- ☐ Burning on urination
- ☐ Urinary frequency
- ☐ Incontinence
- ☐ Joint pain
- ☐ Stiffness
- ☐ Rash
- ☐ Changing moles
- ☐ Headache
- ☐ Seizure
- ☐ Stroke
- ☐ Paralysis
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Thyroid abnormalities
- ☐ Bleeding
- ☐ Anemia
- ☐ Hay fever
- ☐ Hives

_____
Patient Name

_____
Date

**MEDICAL HISTORY:** Check any you have/have had OR check here if None ☐

| | |
|---|---|
| ☐ Anxiety | ☐ Hearing Loss |
| ☐ Arthritis | ☐ Hepatitis |
| ☐ Asthma | ☐ Hypertension (High Blood Pressure) |
| ☐ Atrial Fibrillation (Irregular Heartbeat) | ☐ HIV/AIDS |
| ☐ Bone Marrow Transplantation | ☐ Hypercholesterolemia (High Cholesterol) |
| ☐ BPH (Enlarged Prostate) | ☐ Hyperthyroidism (Overactive Thyroid) |
| ☐ Breast Cancer | ☐ Hypothyroidism (Underactive Thyroid) |
| ☐ Colon Cancer | ☐ Leukemia |
| ☐ COPD (Chronic Breathing Problems) | ☐ Lung Cancer |
| ☐ Coronary Artery Disease (heart disease) | ☐ Lymphoma |
| ☐ Depression | ☐ Prostate Cancer |
| ☐ Diabetes: How long: _____ years<br>Dr.:_____ Location:_____ | ☐ Radiation Treatment<br>☐ Seizures |
| ☐ End Stage Renal Disease | ☐ Stroke |
| ☐ GERD (Acid Reflux) | |
| ☐ Other | |

**SURGERIES:** Check and circle any you have had OR check here if None ☐

| | |
|---|---|
| ☐ Appendix | ☐ Kidney: (Circle) Biopsy, Stone Removal, Transplant, Removal |
| ☐ Bladder | ☐ Liver: (Circle) Removal, Transplant, Shunt |
| ☐ Breast: (Circle) Mastectomy, Lumpectomy, Biopsy: Right or Left | ☐ Ovaries: (Circle) Endometriosis, Cancer, Cyst, Tubal |
| ☐ Colon: (Circle) Cancer, Diverticulitis, Inflammatory Bowel Disease, Colostomy | ☐ Pancreas Removal |
| ☐ Gallbladder | ☐ Prostate: (Circle) Biopsy, Cancer, TURP |
| ☐ Heart: (Circle) Biological Valve Replacement, Bypass, Transplant, Mechanical Valve Replacement, Heart Catheterization, Stent | ☐ Rectum (Circle) APR, Low Anterior Resection |
| ☐ Joint Replacement: (Circle) Knee: Right or Left; Hip: Right or Left | ☐ Skin: (Circle One) Basal Cell Carcinoma, Melanoma, Biopsy, Squamous Cell Cancer |
| | ☐ Spleen Removal |
| | ☐ Testicles Removal |
| | ☐ Uterus (Hysterectomy):(Circle) Fibroids, Uterine Cancer, Cervical Cancer |
| ☐ Other | |

**OCULAR HISTORY:** Check Left, Right, or Both for any you have/have had OR Check here if None ☐

| | |
|---|---|
| ☐ Allergic Conjunctivitis (Pink Eye) | ☐ Glaucoma ☐R ☐L ☐B |
| ☐ Blepharitis | ☐ Macular Degeneration ☐R ☐L ☐B |
| ☐ Cataract ☐R ☐L ☐B | ☐ Narrow Angles ☐R ☐L ☐B |
| ☐ Contact Lenses (OR Check here if interested ☐) | ☐ Ocular Hypertension ☐R ☐L ☐B |
| ☐ Corneal Dystrophy ☐R ☐L ☐B | ☐ Ocular Migraine |
| ☐ Diabetic Retinopathy ☐R ☐L ☐B | ☐ Retinal Tear ☐R ☐L ☐B |
| ☐ Dry Eyes | ☐ Strabismus (Eye Muscle Misalignment) |
| ☐ Glasses | ☐ Vitreous Floaters ☐R ☐L ☐B |
| ☐ Other | |

**OCULAR SURGERIES:** Check any you have had OR check here if None ☐

| | |
|---|---|
| ☐ Blepharoplasty ☐R ☐L ☐B | ☐ LPI (Laser for Narrow Angles) ☐R ☐L ☐B |
| ☐ Cataract Surgery ☐R ☐L ☐B | ☐ LTP (Laser for Open Angle Glaucoma) ☐R ☐L ☐B |
| ☐ Corneal Transplant ☐R ☐L ☐B | ☐ Ptosis Repair ☐R ☐L ☐B |
| ☐ Eye Muscle Surgery | ☐ Punctal Plugs ☐R ☐L ☐B |
| ☐ Intravitreal Injections ☐R ☐L ☐B | ☐ Retinal Laser ☐Diabetes/☐Tear ☐R ☐L ☐B |
| ☐ LASIK (Refractive Laser) ☐R ☐L ☐B | ☐ YAG Capsulotomy ☐R ☐L ☐B |
| ☐ Other | |

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

**FAMILY HISTORY:** Check any for which you have an immediate family history OR check here if None ☐

| | |
|---|---|
| ☐ Blindness<br>☐ Cancer<br>☐ Cataracts<br>☐ CVA (Stroke)<br>☐ Diabetes<br>☐ Glaucoma | ☐ Heart Disease<br>☐ Hypertension (High Blood Pressure)<br>☐ Macular Degeneration<br>☐ Migraines<br>☐ Retinal Detachment<br>☐ Strabismus |
| ☐ Other | |

**MEDICATIONS:** Provide list OR List below (prescribed, non-prescribed, & OTC ) OR check here if None ☐

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

**DRUG ALLERGIES:** List below OR check here if None ☐

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

**SOCIAL HISTORY:** Check any that apply to your status.

| | |
|---|---|
| ☐ Illegal Drug Use | Alcohol Use (Circle one) Never, Rarely, Frequently |
| ☐ Other | |

**SMOKING STATUS: Check one.**

- ☐ Current every day smoker
- ☐ Current occasional smoker
- ☐ Former smoker
- ☐ Never smoked

**DRIVING STATUS**:

- ☐ Drives daytime
- ☐ Drives nighttime

**OCCUPATION:** Check here if retired ☐

**WORKPLACE:**

**RACE:**

- ☐ White
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other race _____

**ETHNICITY:**

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

**PREFERRED LANGUAGE:**

- ☐English
- ☐Other_____

**Race/ethnicity patient information is a Medicare requirement for practices using electronic health records.**

| **PATIENT NAME:** | **DATE:** |
|---|---|
| _____ | _____ |

Reviewed _____

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