

Kumar Eye Institute

Welcome To Our Office

Welcome to Kumar Eye Institute. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Mr. Miss Mrs. Ms. Male Female

First Name MI Last Name Preferred Name

Street Address City State Zip

Social Security Number Date of Birth Home Phone - Include Area Code Day Phone

Email Address Guardian Person Responsible for Account
test, test

Emergency Contact Emergency Phone

How were you referred to our office?

Who were you referred by?

- Phone Book School Advertisement Patient
 Insurance Listing Drive by Other Doctor

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company City State Zip

M F
Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured

- Self Spouse Child Other

Patient Status

- Single Married Other
 Full Time Student Part Time Student Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company City State Zip

M F
Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth Self Spouse Child Other

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Refraction/ Eyeglasses prescriptions are charged \$45 unless covered by a separate Vision Plan.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature

Date

Name: - -

PATIENT HISTORY AND INFORMATION

Race

<input type="checkbox"/> American Indian Or Alaska Native	<input type="checkbox"/> Other Race	<input type="checkbox"/> Refuse To Specify
<input type="checkbox"/> Asian	<input type="checkbox"/> White	<input type="checkbox"/> Not Disclosed
<input type="checkbox"/> Black Or African American	<input type="checkbox"/> Native American	
<input type="checkbox"/> Native Hawaiian Or Other Pacific Islander	<input type="checkbox"/> Caucasian	

Other Race

Ethnicity

Hispanic Or Latino Not Hispanic Or Latino Unknown

Preferred Language

English Spanish French Italian Russian Portuguese

ft	in	cm/m					
Height	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input checked="" type="radio"/> ft in	<input type="radio"/> cm	<input type="radio"/> m	Weight
	<input type="text"/>	<input type="text"/>	<input type="text"/>				<input type="text"/> <input checked="" type="radio"/> lbs <input type="radio"/> kg

For Baby/Young Child: Birth Weight: lbs. oz.

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name

Address of Primary Care Physician City State Zip Phone

REFERRING PHYSICIAN

Referring Physician and Clinic Name

Address of Referring Physician City State Zip Phone

HEALTH HISTORY

What is the main reason for today's exam ? _____ When was your last exam ? _____

When was your last health exam ? _____

Past Illnesses or Injuries: _____

Past Surgeries: _____

Current Medications: _____

Current Eye Drops: _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

EYE HISTORY

Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Dryness	<input type="radio"/> Yes <input type="radio"/> No	Strabismus (Crossed Eyes)	<input type="radio"/> Yes <input type="radio"/> No
Cataract	<input type="radio"/> Yes <input type="radio"/> No	Excess Tearing/Watering	<input type="radio"/> Yes <input type="radio"/> No	Blurred Vision Distance	<input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No	Eye Pain or Soreness	<input type="radio"/> Yes <input type="radio"/> No	Blurred Vision Near	<input type="radio"/> Yes <input type="radio"/> No
Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No	Foreign Body Sensation	<input type="radio"/> Yes <input type="radio"/> No	Distorted Vision (halos)	<input type="radio"/> Yes <input type="radio"/> No
Color Blindness	<input type="radio"/> Yes <input type="radio"/> No	Infection of Eye or Lid	<input type="radio"/> Yes <input type="radio"/> No	Double Vision	<input type="radio"/> Yes <input type="radio"/> No
Headaches	<input type="radio"/> Yes <input type="radio"/> No	Itching	<input type="radio"/> Yes <input type="radio"/> No	Floaters or Spots	<input type="radio"/> Yes <input type="radio"/> No
Glare/Light Sensitivity	<input type="radio"/> Yes <input type="radio"/> No	Mucous Discharge	<input type="radio"/> Yes <input type="radio"/> No	Fluctuating Vision	<input type="radio"/> Yes <input type="radio"/> No
Tired Eyes	<input type="radio"/> Yes <input type="radio"/> No	Drooping Eyelid	<input type="radio"/> Yes <input type="radio"/> No	Loss of Vision	<input type="radio"/> Yes <input type="radio"/> No
Amblyopia (Lazy Eye)	<input type="radio"/> Yes <input type="radio"/> No	Redness	<input type="radio"/> Yes <input type="radio"/> No	Loss of Side Vision	<input type="radio"/> Yes <input type="radio"/> No

Burning Yes No

Sandy or Gritty Feeling Yes No

Name: - -

MEDICAL HISTORY QUESTIONNAIRE

GENERAL HEALTH CONDITION

Fever Yes No
 Weight Loss Yes No
 Other Symptoms Yes No
 Ears,Nose,Throat Yes No
 Cardiovascular (high blood pressure etc.) Yes No

Respiratory (Asthma) Yes No
 Gastrointestinal Yes No
 Kidney Yes No
 Muscles,Bones,Joins Yes No
 Skin Yes No
 Neurological (Multiple Sclerosis) Yes No

Anxiety or Depression Yes No
 Thyroid, Diabetes Yes No
 Blood/Lymph Yes No
 Allergic Yes No
 Pregnant Yes No
 Nursing Yes No

FAMILY HISTORY

Amblyopia (Lazy Eye) Yes No
 Blindness Yes No
 Cataract(s) Yes No
 Color Blindness Yes No
 Glaucoma Yes No
 Macular Degeneration Yes No

Retinal Detachment Yes No
 Strabismus (Eye Turn) Yes No
 Arthritis Yes No
 Cancer Yes No
 Diabetes Yes No
 Heart Disease Yes No

High Blood Pressure Yes No
 Kidney Disease Yes No
 Lupus Yes No
 Stroke Yes No
 Thyroid Disease Yes No
 Others Yes No

SOCIAL HISTORY

Current Occupation : _____ Years _____ Employer _____

SPECTACLE LENS HISTORY

Do you use a computer? Yes No How many hours/day? _____ Distance from Computer? _____
 Do you drive? Yes No Mileage to work each way? _____
 Do you have glare problems? Yes No
 Do you have visual difficulty when driving? Yes No
 Do you have problems with night vision? Yes No
 Do you currently wear glasses ? Yes No Since _____
 Type of glasses FullTime PartTime Distance Close
 Glasses Owned SingleVision Bifocals Trifocals Backup Safety Sports Progressive
 Have you had trouble in the past with glasses? Yes No _____
 Do you wear sunglasses? Yes No Are your sun glasses your current prescription ? Yes No

SPECIAL EYEWEAR NEEDS

Computer (special prescriptions, special anti-glare tints or coatings) Safety Glasses (gardening, woodworking, welding)
 Occupational (mechanics, plumbers, pilots) Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY

If not a contact lens wearer, are you interested in trying contact lenses at this time ? Yes No
 Have you ever tried to wear contact lenses? Yes No Reason for stopping? _____
 Do you currently wear contact lenses? Yes No Since _____
 Type and brand of contact lenses _____ Today's wearing time ? _____
 How many hours/day ? _____ How many days/week ? _____

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

Right Left Right Left Right Left

Lens Comfort _____ Distance Vision _____ Near Vision _____

What Solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____

Name: - -

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? Yes No

Do you engage in regular exercise? Yes No

Do you drink alcohol ? If yes, how much/often : No Occasional 1 Per Day 2-3/day 4+/day

Do you smoke ? If yes, how much/often : No Occasional 1/2 pack/day 1 pack/day 1+ pack

Smoking Status

Method of Tobacco Intake : Smoking Chewing

Do you use Illegal Drugs : Yes No

Hobbies/ Interests : _____