Kirks Eye Center, P.C.

100 Brevco Plaza, Suite 108 · Lake Saint Louis, MO 63367 · (636) 561-6000

Date_____

PATIENT INFORMATION

Last Name _____First Name_____ MI____ Preferred Name _____Suffix_____
Street Address _____Apt_____ City _____State _____Zip _____
Home Phone _____Cell Phone_____ Daytime Phone _____Date of Birth _____
Gender: Male / Female Race _____ Ethnicity _____Language _____ SS# _____
Email Address _____Preferred Method of Contact _____
Occupation (grade) _____ Employer (school) _____ Work Address _____
Spouse _____ Spouse's Occupation and Employer _____
Emergency Contact Name _____ Relationship _____ Phone Number _____
Parent/Guardian _____ Phone Number(s) _____
Dependent Children _____
Whom do we thank for referring you to our practice? Doctor Family Friend Insurance Website Other _____

INSURANCE INFORMATION

Primary Vision Coverage _____ ID No. _____ Group No. _____
Subscriber _____Subscriber's SS#_____ DOB _____ Phone Number _____
Other Vision Coverage _____ ID No. _____ Group No. _____
Subscriber _____Subscriber's SS#_____ DOB _____ Phone Number _____
Medical Insurance _____ ID No. _____ Group No. _____
Subscriber _____Subscriber's SS#_____ DOB _____ Phone Number _____
Do you participate in a medical savings through your employer? Yes No

ASSIGNMENT

I, the undersigned, certify that I have insurance coverage with _____ and assign directly to Kirks Eye Center, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____**Date** _____

SPECIAL TESTING

Pupillary dilation allows the doctor to evaluate the inside of the eye and look for retinal holes, tears, degenerations, glaucoma, or other diseases such as diabetes and hypertension. Our Optomap technology allows the doctor to scan the retina and provides an image of most of the internal structures without dilation. Either method, pupillary dilation or Optomap scanning, will allow a view into the retina. Even with imaging, dilation may be required to view certain pathology.

I prefer Optomap scanning _____ ($25 fee) **I prefer dilation _____**
I refuse dilation and assume responsibility for any undetected pathology _____

MEDICAL HISTORY

How is your general health? _____ Are you currently under the care of a physician? Yes No
Primary Care Physician _____ Phone number _____ Date of Last Visit _____
Specialty Physician _____ Phone number _____ Date of Last Visit _____
Pharmacy _____ Phone number _____
Have you had any eye surgeries? Yes No If yes, what type _____ Date _____
Have you had an eye injury? Yes No If yes, describe _____
Have you ever worn contact lenses? Yes No If yes, what type? _____
Have you ever had problems with your contacts lenses? _____
If our exam indicates that contact lenses would be suitable for you, would you be interested in them? Yes No

MEDICAL HISTORY CONTINUED
Date of Last Eye Exam
Currently Wear Glasses?
Reason for Today's Visit

Have you or a family member experienced, or been treated for any of the following? Circle all that apply.			
Cataracts	yes	no	family
Crossed Eye/ Lazy Eye	yes	no	family
Glaucoma	yes	no	family
LASIK or RK	yes	no	family
Macular Degeneration	yes	no	family
Retinal Detachment	yes	no	family

Are you currently experiencing or have experienced, any of the following?		
Blurry Vision	yes	no
Burning	yes	no
Infection of Eye	yes	no
Infection of Lid	yes	no
Discharge	yes	no
Distorted Vision/Halos	yes	no
Double Vision	yes	no
Dryness	yes	no
Excess Tearing/Watering	yes	no
Eye Pain or Soreness	yes	no
Flashes of Light or Floaters	yes	no
Foreign Body Sensation	yes	no
Glare	yes	no
Headaches	yes	no
Itching	yes	no
Light Sensitivity	yes	no
Loss of Side Vision	yes	no
Loss of Vision	yes	no
Redness	yes	no
Sandy or Gritty Feeling	yes	no
Sties or Chalazia	yes	no
Tired Eyes/Fatigue	yes	no
Other Eye Problems		

Height:	**Weight:**			
Are you pregnant or nursing?		yes	no	
Do you smoke?		yes	no	
Packs per day?				
Have you ever smoked?		yes	no	
When did you quit smoking?				
Do you use illegal drugs?		yes	no	
Do you drink alcohol?	yes no	Social Drinker?	yes	no
Frequency:	Amount:			

Additional Concerns:

Doctor's Signature	**Date**
Doctor's Signature	**Date**
Doctor's Signature	**Date**

REVIEW OF SYSTEMS		
Allergies	yes	no
Blood/Lymphatic Conditions	yes	no
Anemia	yes	no
Sickle Cell	yes	no
Cancer		
Cardiovascular	yes	no
Heart Disease	yes	no
High Cholesterol	yes	no
Hypertension	yes	no
Constitutional	yes	no
Fever	yes	no
Recent Illness	yes	no
Ears, Nose, Throat Conditions	yes	no
Endocrine	yes	no
Diabetes	yes	no
Insulin Use	yes	no
Duration: years B/S: A1C:		
Thyroid Dysfunction	yes	no
Gastrointestinal Conditions	yes	no
Genitourinary	yes	no
Sexually Transmitted Diseases	yes	no
Immunologic	yes	no
AIDS/HIV	yes	no
Autoimmune Conditions	yes	no
Lupus	yes	no
Sjogren's Syndrome	yes	no
Musculoskeletal	yes	no
Arthritis	yes	no
Neurological Conditions	yes	no
Headache/Migraine	yes	no
Psychiatric Conditions	yes	no
Stroke	yes	no
Respiratory	yes	no
Asthma	yes	no
Skin Condition	yes	no

Current Medications
Prescription and over the counter please list dosage

Medication Drug Allergies

Do you work on a computer? Hours per day	yes	no
Do you play Video games? Hours per day	yes	no
Do you experience difficulty with driving, especially at night?	yes	no
Do you have any hobbies which require special visual needs, or which you are having difficulty seeing?	yes	no

Patient Signature	**Date**
Patient Signature	**Date**
Patient Signature	**Date**