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) _____
Dependant Children _____
Kirks Eye Center has my permission to leave messages on my voicemail Yes No
Whom do we thank for referring you to our practice? Doctor _____ Facebook Family Friend Google Insurance LinkedIn Twitter Website Yellow Pages 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 dilation ____ I prefer Optomap scanning ___ Please be advised there is a $35 fee associated with the Optomap Scan.
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
Name, address and phone number of family doctor and/or primary care physician _____
Specialty Physician_____ 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 contact 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.

Astigmatism	yes	no	family
Cataracts	yes	no	family
Crossed Eye	yes	no	family
Farsighted	yes	no	family
Glaucoma	yes	no	family
LASIK or RK	yes	no	family
Lazy Eye	yes	no	family
Macular Degeneration	yes	no	family
Nearsighted	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
Chronic Infection of Eye	yes	no
Chronic 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 Infection	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	yes	no
Other Eye Problems		

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

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	yes	no
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?		
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	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**