Name: ________________________________ Pharmacy/location: ________________________________

Allergies: ________________________________ If ALL NORMAL below, check this box ☐

Review of Systems*

Eyes

Previous Surgery	☐ Yes	☐ No
Contact Lens	☐ Yes	☐ No
Pain	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No
Macular Degeneration	☐ Yes	☐ No
Dry Eyes	☐ Yes	☐ No
Flashes	☐ Yes	☐ No
Floaters	☐ Yes	☐ No

Ear, Nose, and Throat*

Hard of Hearing	☐ Yes	☐ No
Ringing in Ears	☐ Yes	☐ No
Vertigo	☐ Yes	☐ No

Respiratory*

Cough	☐ Yes	☐ No
Congestion	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Asthma	☐ Yes	☐ No

Cardiovascular*

Chest Pain	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No
Difficulty Lying Flat	☐ Yes	☐ No

Gastrointestinal*

Heartburn	☐ Yes	☐ No
Nausea/Vomiting	☐ Yes	☐ No
Jaundice/Hepatitis	☐ Yes	☐ No

Genito-Urinary*

Pain/Difficulty	☐ Yes	☐ No
Blood in Urine	☐ Yes	☐ No
History of Kidney Stones	☐ Yes	☐ No
History of STDs	☐ Yes	☐ No

Psychiatric*

Anxiety/Depression	☐ Yes	☐ No
Mood Swings	☐ Yes	☐ No
Difficulty Sleeping	☐ Yes	☐ No

Blood/Lymph Nodes*

Easy Bruising	☐ Yes	☐ No
Gums Bleed Easily	☐ Yes	☐ No
Prolonged Bleeding	☐ Yes	☐ No
Heavy Aspirin Use	☐ Yes	☐ No

Musculoskeletal*

Stiffness	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Joint Pain/Swelling	☐ Yes	☐ No

Skin*

Rash/Sores	☐ Yes	☐ No
Lesions	☐ Yes	☐ No
Hives/Eczema	☐ Yes	☐ No

Neurological*

Seizures	☐ Yes	☐ No
Weakness/Paralysis	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Tremors	☐ Yes	☐ No

Do you have diabetes? ☐ No ☐ Yes, since ______________________

Family history: ☐ Diabetes ☐ Stroke ☐ Macular degeneration ☐ Cancer ☐ Detached Retina

Social history: Smoking Status: ☐ Current smoker – amount ________________
☐ Former smoker
☐ Never smoked

Alcohol use: ☐ No ☐ Yes amount ____________________

Drug use: ☐ No ☐ Yes amount ____________________

Medications:

____

____

____

____

PATIENT PORTAL: To view a summary of your records, visit Kalilneye.com and click on the Patient Portal link on the homepage. You will need to register and enter your information *exactly* as it is listed with the office. Your SS# is needed. The initial password is Kalineye. Log in with your email. It may take up to 72 hours for your information to be posted.

Patient Name ________________________________
Last First Middle

Address ________________________________

City, State, Zip ________________________________

Phone: (   ) ________________________________

Cell: (   ) ________________________________

Age: _____ DOB: ______________ Sex: M F

SS#: _________________ Marital Status (S M W D)

Email: ________________________________

Primary Physician: ________________________________

Occupation: ________________________________

Employer: ________________________________

Employer Phone: ________________________________

Guarantor Name: ________________________________

Employer: ________________________________

Phone: (   ) ________________________________

Emergency Contact ________________________________

Phone: (   ) ________________________________

Race: ☐ White ☐ Black/African Amer. ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Other ☐ Native Hawaiian/Pacific Islander

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Preferred Language: ☐ English ☐ Spanish ☐ French ☐ Italian ☐ Japanese ☐ Portuguese ☐ Russian ☐ Other____________

Primary Insurance ________________________________ Secondary Insurance________________________________

Vision plan ______________________ PLEASE TELL STAFF IF YOU ARE USING A VISION PLAN – THIS IS VERY IMPORTANT. IF THIS IS NOT INDICATED, YOU MAY BE RESPONSIBLE FOR ALL CHARGES!!

REASON FOR TODAY'S VISIT: ____

CONSENT FOR DILATING EYE DROPS

A COMPLETE eye exam usually includes the use of drops to dilate your pupils. Dilation usually causes blurred vision and light sensitivity. Some people find driving very difficult following dilation. We strongly suggest you do not drive until you are comfortable doing so. If you wish to return for a second visit for dilation, you will be charged for another visit. If you choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for injuries to yourself or others. In addition, we strongly suggest you use sunglasses to reduce your increased sensitivity to light while driving. We will provide shades to you at no charge if requested. Your signature below indicates that you have been warned of the potential risks that dilating eye drops may have on your ability to drive.

Patient ________________________________ Date: ________________________________

SIGNATURE ON FILE

I request that payment of authorized Medicare, Medigap or any other insurance benefits be made either to me or on my behalf to KALIN EYE ASSOCIATES for any services furnished me by its physicians.

It is understood that the responsibility for all charges remains with the patient. Additionally, payment is to be made at the time or service for amount not paid by insurance. I authorize any holder of medical information about me to release to all my insurance companies or to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I permit a copy of this authorization to be used in place of the original.

________________________________ Date: ________________________________

Signature of Patient or Responsible Party

________________________________ Date: ________________________________

I have received a copy of the notice of privacy practices

By signing above, I give Dr. Kalin/staff my permission to discuss my care with:

☐ Spouse ☐ Parent ☐ Children ☐ No family members (CONTINUES ON OTHER SIDE)