

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
Pref.Lang: English Spanish French Italian Japnse Portug 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 includes the use of drops to dilate your pupils. Dilation usually causes blurred vision. Some people find driving very difficult following dilation. We strongly suggest you do not drive until you are comfortable doing so. If you wish, you may return for a second visit at no charge (within 90 days) for dilation. 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 **X** _____ 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.

X _____ Date _____
 Signature of Patient or Responsible Party

X _____ 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 ----->)

NAME: _____ Pharmacy/location: _____

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

Respiratory *

Cough YES NO
Congestion YES NO
Wheezing YES NO
Asthma YES NO

Blood/Lymphnodes *

Easy Bruising YES NO
Gums Bleed Easily YES NO
Prolonged Bleeding YES NO
Heavy Asprin Use YES NO

Gastrointestinal *

Heartburn YES NO
Nausea/Vomiting YES NO
Jaundice/Hepatitis YES NO

MusculoSkeletal *

Stiffness YES NO
Arthritis YES NO
Joint Pain/Swelling YES NO

Ear, Nose, and Throat *

Hard of Hearing YES NO
Ringing in Ears YES NO
Vertigo YES NO

Genito-Urinary *

Pain/Difficulty YES NO
Blood in Urine YES NO
History of Kidney Stones YES NO
History of STD's YES NO

Skin *

Rash/Sores YES NO
Lesions YES NO
Hives/Eczema YES NO

Cardiovascular *

Chest Pain YES NO
Dizziness YES NO
Fainting Spells YES NO
Shortness of Breath YES NO
Irregular Heart Beat YES NO
Difficulty Lying Flat YES NO

Psychiatric *

Anxiety/Depression YES NO
Mood Swings YES NO
Difficulty Sleeping YES NO

Neurological *

Seizures YES NO
Weakness/Paralysis YES NO
Numbness YES NO
Tremors YES NO

Allergies: _____

If ALL NORMAL below, check this box

Do you have diabetes? No Yes, since _____

Family history: Diabetes Stroke Macular degen Cancer detached retina

Social history: Smoking status Current smoker – amount _____
 Former smoker
 Never smoked

Alcohol use No Yes Amount: _____

Drugs: No Yes Amount: _____

Medications:

PATIENT PORTAL: To view a summary of your records, visit Kalineye.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. Login with your email. It may take up to 72 hours for your information to be posted.

