

# WELCOME TO HEART OF AMERICA EYE CARE

## PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
Birth Date \_\_\_\_\_ Gender:  M  F Marital Status:  S  M  D  W  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security # \_\_\_\_\_ Email\* \_\_\_\_\_  
Phone:  HOME \_\_\_\_\_  CELL \_\_\_\_\_  WORK \_\_\_\_\_  
*Check preferred contact number*  
Race \_\_\_\_\_ Ethnicity:  Hispanic/Latino  Other  Decline to answer  
Primary Language:  English  Spanish  Other \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
Preferred Pharmacy \_\_\_\_\_ Address \_\_\_\_\_

## EMERGENCY INFORMATION

Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone: H C W (circle) \_\_\_\_\_ H C W (circle) \_\_\_\_\_

## PATIENT EMPLOYMENT INFORMATION

Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**How did you hear about us?**  Internet  Friend/family  Doctor  Other \_\_\_\_\_

With whom may we speak about financial statements, test results, or other services provided by our office regarding your medical treatment? *(list all that apply)*

Name(s)/relationship: \_\_\_\_\_ **No one**

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments; however, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered, unless other arrangements have been made in advance.

**AUTHORIZATION:** I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to Heart of America Eye Care, P.A. for any services furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid services or its intermediaries or carriers any information needed for this or related to a Medicare/other insurance company claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the healthcare provider or any other party may be responsible for paying for my treatment.

\*We may use your email address to send you appointment reminders or information about our practice and specials. However, we will not share your email address with any other person or organization.

- I acknowledge receipt of notice of privacy practices.
- I authorize Heart of America to view my prescription from external sources.
- I acknowledge that I have read and understand the office policies.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

*Or signature of parent or legal guardian if patient is under 18 years of age.*

**Patients under 18 must have a parent/guardian present at exam OR written consent/Minor Consent Form.**

# HEART OF AMERICA EYE CARE

## Medical History

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Today's date \_\_\_\_\_

Why are you here today? \_\_\_\_\_

➡ Circle "S" if you have the condition or "F" if a family member has the condition:

<b>EYE</b>			S	Ulcerative colitis
S F Cataracts			S	Abdominal pain
S F Glaucoma	S	<b>MUSCULOSKELETAL</b>		
S Dry eyes	S	Arthritis		
S F Macular degeneration	S	Joint pain		<b>URINARY</b>
S F Retinal tear/detachment	S	Muscle aches	S	Enlarged prostate
S F Fuch's Dystrophy	S	Low back pain	S	Blood in urine
S F Lazy eye/strabismus			S	Excessive urination
S Prior LASIK/PRK/RK	S F	<b>IMMUNOLOGIC</b>	S	Pain w/ urination
	S F	Rheumatoid arthritis		
	S F	Sjogren's syndrome		<b>NEUROLOGIC</b>
<b>HEART</b>	S F	Lupus	S	Depression
S F High blood pressure	S F	Sarcoidosis	S	Anxiety
S F Coronary artery disease	S	Juvenile rheumatoid arthritis	S	Headaches
S F Congestive heart failure	S F	Ankylosing spondylitis	S	Migraines
S F Irregular heart beat	S F	HLA-B27	S	Numbness
S Chest pain	S F	Myasthenia gravis	S	Weakness
S Vascular problems			S F	Alzheimer's disease
		<b>EAR, NOSE, THROAT</b>	S	Memory loss
	S	Seasonal allergies		
<b>RESPIRATORY</b>	S	Hearing loss		<b>GENERAL HEALTH</b>
S Asthma	S	Sinus problems	S	Fatigue
S COPD/emphysema	S	Sore throat	S	Unexpected weight loss/gain
S Sleep apnea			S	Hepatitis
S Shortness of breath		<b>SKIN DISORDERS</b>	S	HIV/AIDS
S Wheezing	S	Rosacea		
S Coughing	S	Eczema		<b>CANCER</b>
	S	Excessive dry skin	S F	Melanoma
<b>ENDOCRINE</b>			S	Skin cancer
S F High cholesterol		<b>GASTROINTESTINAL</b>	S F	_____
S Type I diabetes since _____	S	Acid reflux	S F	_____
S F Type 2 diabetes since _____	S	Ulcers		
S Thyroid disorder	S	Crohn's disease		
S F Grave's disease	S			

Other conditions not listed above \_\_\_\_\_

Eye medications/drops \_\_\_\_\_

Other medications (or attach list) \_\_\_\_\_

Allergies (medications, food, etc) \_\_\_\_\_

Eye surgeries \_\_\_\_\_

Major surgeries (with date); minor surgeries in last 5 years \_\_\_\_\_

Do you smoke? Never Current Former \_\_\_\_\_ packs/day for \_\_\_\_\_ years (quit \_\_\_\_\_ yrs ago)

Do you drink alcohol? No Rare Yes \_\_\_\_\_ drinks per (circle): day week month

# HEART OF AMERICA EYE CARE, P.A.

Bradley Kwapiszeski, MD · Jodianne Carter, MD · Caroline Chang, MD  
Brenda Edwards, OD · Laura Brammer, OD · Stephanie Erker, OD

Due to many changes with insurance plans and from healthcare reform, NOT all insurance plans cover a routine eye/vision exam. It is the responsibility of the insured to know the EXACT benefits of their insurance plan. You must inform us whether your visit will be a medical exam or a routine vision exam.

**NO CHANGES CAN BE MADE AFTER THE EXAM IS COMPLETED.**

**MEDICAL** (i.e. diabetes, cataracts, glaucoma, red eye, floaters)

**ROUTINE VISION** (i.e. glasses, contact lens evaluation)

**DO YOU HAVE A VISION PLAN? VSP Eyemed Spectera VCP**  
(circle)

Primary Member \_\_\_\_\_

Birth Date \_\_\_\_\_ SSN \_\_\_\_\_

Please provide ALL of your insurance cards at your appointment.

We will file the insurance you designate and cannot re-file after your date of service.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date