

**Koury Family Eye Care – Patient Registration**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Gender:  Male  Female  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Preferred Phone:  Cell  Home  
eMail Address: \_\_\_\_\_  
Name of Parents (if patient is Minor): \_\_\_\_\_

Do you currently wear Glasses?  No  Full Time  For Distance Only  For Near Only  For Computer Only  Worn in the Past  
Are you interested in wearing Contact Lenses?  No  Yes ⇨  Current Wearer  Worn in the Past  First Time Wearer

INSURANCE INFORMATION

Are you covered by any of these Vision Plans?  Davis  Spectera  EyeMed  NVA  Superior  Avesis  VSP

Do you have Medicare?  No  Yes ⇨ Medicare Supplement \_\_\_\_\_

Do you have a Medicare Advantage Plan?  No  Yes ⇨ With which company? \_\_\_\_\_

Do you have Medical Insurance with:  Capital Blue Cross  Highmark Blue Shield  Other Blue Cross / Blue Shield  
 Aetna  United Healthcare  Cigna  
 Coventry  Other \_\_\_\_\_

Koury Family Eye Care provides both Routine eye examination services and Medical (health) eye care. When applicable, Koury Family Eye Care will bill in-network Vision Plans (Davis Vision, EyeMed, etc.) for routine eye examinations. However, if a medical eye condition (ie. glaucoma, eye injury, infection, diabetes, or other condition) requires evaluation, testing, or treatment, Koury Family Eye Care must bill your Medical Insurance in accordance with insurance contractual agreements.

*The following statements are applicable if the patient is utilizing insurance benefits.*  
I authorize release of any medical information and medical records to my insurance company necessary to process a claim.  
I authorize payment of benefits to be made directly to Koury Family Eye Care, LLC for services rendered to me.  
I authorize use of this form on all of my insurance submissions and permit a copy of this authorization to be used in place of the original.  
I understand that I am fully responsible for payment of any Co-Insurance, Co-Payments, Deductibles, and any other charges that are incurred that are not covered by my insurance.  
I understand this office does not in any way guarantee payment for my exam by accepting my insurance plan.

I acknowledge that a copy of this office's *Notice of Privacy Practices* has been made available to me.

\_\_\_\_\_  
*Signature of Patient, Guardian, or Authorized Representative* \_\_\_\_\_  
*Date*

# Koury Family Eye Care – Medical History

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## Current Eye History: Are YOU currently experiencing any of the following?

- |  |                                   |  |  |   |
|--|-----------------------------------|--|--|---|
| <input type="checkbox"/> NONE                    | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Contact Lens Issues | <input type="checkbox"/> Seeing Flashes of Light | <input type="checkbox"/> Glare at Night     |
| <input type="checkbox"/> Blurred Distance Vision | <input type="checkbox"/> Redness  | <input type="checkbox"/> Eye Pain            | <input type="checkbox"/> Seeing Spots in Vision  | <input type="checkbox"/> Difficulty Driving |
| <input type="checkbox"/> Blurred Near Vision     | <input type="checkbox"/> Tearing  | <input type="checkbox"/> Mucous/Discharge    | <input type="checkbox"/> Headaches               | <input type="checkbox"/> Double Vision      |
| <input type="checkbox"/> Blurred Computer Vision | <input type="checkbox"/> Burning  | <input type="checkbox"/> Itching             | <input type="checkbox"/> Loss of Vision          |   |

## Previous Eye History: Do YOU have a history of any of the following?

- |                                    |   |  |                                      |
|------------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> NONE      | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Strabismus (Eye Turn) | <input type="checkbox"/> Eye Injury  |
| <input type="checkbox"/> Glaucoma  | <input type="checkbox"/> Corneal Disorders    | <input type="checkbox"/> Amblyopia (Lazy Eye)  | <input type="checkbox"/> Eye Surgery |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Retinal Disorders    | <input type="checkbox"/> Patching              |                                      |

## Family History: Does anyone in YOUR FAMILY (Parents, Grandparents, Siblings) have a history of any of the following?

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> NONE                 | <input type="checkbox"/> Retinal Disorders | <input type="checkbox"/> Fuch's Dystrophy      | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Blindness         | <input type="checkbox"/> Strabismus (Eye Turn) | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Keratoconus       | <input type="checkbox"/> Amblyopia (Lazy Eye)  |  |

## Systemic History: Do YOU have a history of any of the following? Many systemic conditions can also affect your eyes.

### Currently Pregnant or Nursing

- No  Yes

### Constitutional

- NONE  
 Developmental Disability  
 Cancer / Tumor  
 Fatigue Syndrome

### Cardiovascular

- NONE  
 High Blood Pressure  
 Stroke  
 Heart Disease  
 Arteriosclerosis  
 Mitral Valve Prolapse

### Endocrine

- NONE  
 Diabetes  
 Thyroid dysfunction  
 Hormonal dysfunction

### Smoking History

- Never  
 Former  
 Current

### Musculoskeletal

- NONE  
 Fibromyalgia  
 Muscular Dystrophy  
 Gout

### Gastrointestinal

- NONE  
 Crohn's Disease  
 Colitis

### Genitourinary

- NONE  
 Kidney disease  
 Prostate disease/cancer

### Hematologic / Lymphatic

- NONE  
 High Cholesterol  
 Anemia  
 Large-volume blood loss  
 Leukemia

### Ears/Nose/Throat/Mouth

- NONE  
 Hearing Loss  
 Sinusitis  
 Dry Mouth

### Allergic / Immunologic

- NONE  
 Environmental Allergies  
 Rheumatoid Arthritis  
 Lupus  
 Sarcoidosis  
 Sjögren's Syndrome

### Integumentary

- NONE  
 Eczema  
 Rosacea  
 Psoriasis

### Psychiatric

- NONE  
 Depression  
 ADD / ADHD

### Neurological

- NONE  
 Multiple Sclerosis  
 Epilepsy  
 Alzheimer's Disease  
 Autism Spectrum Disorder  
 Migraines  
 Head Injury

### Respiratory

- NONE  
 Asthma  
 Bronchitis  
 Emphysema  
 Sleep Apnea  
 COPD

### Infectious

- NONE  
 Lyme Disease  
 STD - Herpes/Chlamydia/Syphilis  
 HIV / AIDS  
 Tuberculosis  
 Hepatitis  
 Shingles

Who is your family Physician? \_\_\_\_\_

## Medications: (If you have a written list, our staff can copy it)

- NONE \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Allergies to Medications:

- NONE \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_