MIDTOWN EYECARE

Dr. Kyle Craig
1701 S Peoria Ave, Suite 200 Tulsa, OK 74120
Phone: 918.599.0202 Fax: 918.599.0279

In order to serve you properly, our staff needs the following information. This information is confidential.

Today's Date _____ / _____ / _____ Date of Last Eye Exam: _____ / _____ / _____

Last Name: _____ First Name: _____ MI: ____ M ___ F ____

Goes by: _____ Marital Status (circle): Married Single Widowed Divorced

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

E-mail Address: _____ DOB: _____ SSN: _____

Employer: _____ Occupation: _____

Address: _____

Name of Parent / Spouse: _____ Employer: _____

Parent / Spouse work phone: _____

Method of Payment/ Insurance Information:

Insurance _____ Medicare _____ Medicaid _____ Check _____ Cash _____ Credit Card _____

Name of Insured: _____ Relationship to Patient: _____

Insured DOB: _____ Insurance Company: _____

Member ID: _____ Member SSN: _____ Group #: _____

Do you have a Secondary Insurance? Yes _____ No _____ (If yes, please complete the following)

Name of Insured: _____ Relationship to Patient: _____

Insured DOB: _____ / _____ / _____ Member Insurance Company: _____

Member ID: _____ Member SSN: _____ Group #: _____

Authorization & Release:

I hearby assign and authorize my insurance carrier(s) to issue payment (checks) directly to Midtown EyeCare for medical and/or visual services rendered or my dependents. I understand that I am responsible for any billed amount not covered by insurance. I authorize release of any information concerning my or my child care, advice given, and treatment provided for the purpose of evaluating claims for insurance benefits and agrees to allow a photocopy of my signature to be used to produce insurance claims.

Signature of Patient _____ Date: _____

Signature of Parent or Responsible Party _____ Date: _____

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HIPPA

Our Notice of Privacy Practices:

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this Notice at any time as allowed by law. If we change this Notice, the new Privacy practices will apply to your health information that we may generate in the future. If we change our Notice of privacy practices, we will post the new copy in our office and have copies available to you in our office.

Appointment Reminders:

We may call or write you of scheduled appointments, or that it is time to make a routine appointment. We may call or write you of other treatments or services available at our office that might help you.

Other Uses and Disclosures:

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form". The content of an "authorization form" is determined by federal law. We may initiate the authorization process if the use or disclosure is our idea, and you may as well initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us properly completed authorization form, or you can use one of ours.

For additional information, please ask.

ACKNOWLEGE OF RECEIPT:

I acknowledge that I understand the copy of Dr. Kyle Craig's Notice of Privacy Practices:

Patient Name: _____

Signature: _____ Date: _____
(Must be signed by a parent or guardian if patient is a minor)

History and Physical Information

Patient Name: _____ Date: _____

DOB: _____ Age: _____ Date of last medical exam: _____

Primary Care Physician: _____ Phone: _____

Do you have any allergies to medications? □ Yes □ No If yes, please explain

_____

Current Medications: (if you have a list we would be happy to make a copy)

_____

_____

_____

Please list any previous surgeries and year: _____

_____

_____

Please comment if applicable:

□ Heart Problem: □ Heart Attack, what year _____ □ Irregular Heartbeat

□ Murmur □ Pacemaker □ other: _____

□ High blood pressure: □ Stroke when? _____

□ Lungs: □ Asthma □ Emphysema/COPD □ Bronchitis □ TB

□ Seasonal allergies: □ other: _____

□ Liver Disease: □ Hepatitis: type _____ □ Jaundice □ other: _____

□ Kidneys: □ Dialysis □ Transplant

□ Diabetes: □ Diet Control □ Oral Meds □ Insulin □ Insulin Pump

□ Other: _____

□ Digestive Disorders: □ Ulcer □ Hiatal Hernia □ Acid Reflux □ Other: _____

□ Arthritis □ Bleeding Disorder

Have you ever been exposed or infected with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis □ none

If female of childbearing years: □ I am not pregnant □ I am pregnant

□ Possibility that I am pregnant

Family History

Please note any family history (parents, grandparents, siblings, children (living or deceased) of the following: Please specify family member in space provided.

Blindness	□ Yes □ No	_____
Cataract	□ Yes □ No	_____
Crossed Eyes	□ Yes □ No	_____
Glaucoma	□ Yes □ No	_____
Macular Degeneration	□ Yes □ No	_____
Retinal Detachment/Disease	□ Yes □ No	_____
Arthritis	□ Yes □ No	_____
Cancer	□ Yes □ No	_____
Diabetes	□ Yes □ No	_____
Heart Disease	□ Yes □ No	_____
High Blood Pressure	□ Yes □ No	_____
Kidney Disease	□ Yes □ No	_____
Lupus	□ Yes □ No	_____
Thyroid Disease	□ Yes □ No	_____
Other	□ Yes □ No	_____

Please Circle any of the following you have had:

crossed eyes lazy eye drooping eyelid prominent eyes glaucoma
retinal disease cataracts eye infections eye injury

Please Comment if Applicable:

I have: □ Contacts. When was the last time you wore contacts? _____

I have: □ Glasses. How old is your current pair of lenses? _____

I smoke: □ Cigarettes □ Cigar □ Pipe How much and for how long? _____

I drink alcohol: □ daily □ weekly □ occasionally