

**Welcome To J.KIM EYECARE**

*Thank you for choosing our practice for your eyecare needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.*

|  |  |
| --- | --- |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_  Birth Date: **\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_** Social Security #: **\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_** | Date**\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_**  Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Insurance Information**

|  |  |
| --- | --- |
| Name of who is responsible for this account  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Primary Medical Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Vision Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the Patient or the Patient’s Representative) authorize payment from my insurance company to be made to J.KIM EYE CARE OD, PLLC for **covered** services. I certify that the insurance information provided is correct and I am responsible for any missing information. **Having insurance is not considered as a substitute of payment**. Ultimately, it is my responsibility for payments such as co-payments and any non-covered fees. However, I will be provided with the necessary information to submit the claim myself, for reimbursement. Any questions as to why my plan paid or denied a claim should be directed to my insurance company, as it is impossible for the staff to be familiar with the requirements of all group plans since they vary. Therefore, by signing; I am aware that as the patient, I am financially responsible for any charges not paid under this insurance policy. |

**Notice of Privacy Practice**

# I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Print Full Legal Name) have been presented with the Notice of Privacy Policy (the laminated document on the clipboard) of JKIM EYE CARE, OD, PLLC. Please feel free to ask us for a copy.

**OFFICE POLICY, CANCELLATION, NO-SHOW & FOLLOW-UP’S**

The following is one of many policies regarding cancellations, no-shows and follow-up’s, payment, fees:

* We require 24 hours’ notice in the event of a cancellation and/or rescheduling appointment.
* Glasses prescription re-checks are limited to one visit within one month of original exam (**only exams done by us**.)
* There is a $25.00 charge for a cancellation and/or missed appointment without proper notice. This charge will not be covered by insurance and will have to be paid by you personally.
* If any outstanding balance has not been taking care of prior to your next visit, we have right to cancel your appointment and in event, third party colleting agency service involves then you are entirely responsible for any fees incurred during collecting payment.
* There will be administration fee for preparation documentations upon requested (copy of chart, mail, letters)
* We have right to change our policies without prior written notice.

I HAVE READ AND UNDERSTAND THE POLICIES ABOVE THAT APPLY TO ME.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Print Name Patient or Patient’s Representative Signature Date

**Social History-** This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

 Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive?  No  Yes If yes, do you have visual difficulty when driving?  No  Yes If yes, please describe:

Do you use tobacco products?  No  Yes If yes, type/amount/how long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol?  No  Yes If yes, type/amount/how long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use illegal drugs?  No  Yes If yes, type/amount/how long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis

**Medical History**

Do you have any allergies to medications?  No  Yes If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all major injuries, surgeries and/or hospitalizations you have had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant and/or nursing?  No  Yes Do you wear eyeglasses?  No  Yes

Do you wear contact lenses?  No  Yes If yes, what brand? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are they comfortable?  No  Yes

**Family History** Please note *any* family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Disease/Condition**  Thyroid Disease  Diabetes  Hypertension  Cancer  Strabismus  Cataract  Glaucoma Suspect | **NO**               | **YES**               | **Relationship**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Disease/Condition**  Amblyopia  Severe Myopia  Macular Degeneration  Retinal Detachment  Glaucoma  Severe Hyperopia  Other | **NO**               | **YES**               | **Relationship**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Review of Systems** Do you currently, or have you ever had any problems in the following areas:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Eyes**  Itching  Diplopia  Burning  Loss of Vision  Redness  Flashes/Floaters  Tearing/Watering  **Neurological**  Headaches/Migraines  Multiple Seizures  Cerebral Palsy  Tumor  **Gastrointestinal**  Constipation/Diarrhea  Ulcer | **NO**                                     | **YES**                                   | **Ear, Nose, Mouth, Throat**  Sinusitis  Dry Throat/Mouth  Hearing Loss  **Constitutional**  Fever, Weight Loss/Gain  **Psychiatric**  Depression/Anxiety/Bipolar  **Vascular/Cardiovascular**  Vascular Disease  Stroke  Heart Disease/Heart Pain  High Blood Pressure  **Hematologic/Lymphatic**  Anemia  High Cholesterol  **Integumentary** (Skin) | **NO**                                 | **YES**                                 | **Genitourinary**  Genital/Kidney/Bladder  **Musculoskeletal**  Muscle/Joint Pain  Arthritis  **Endocrine**  Diabetes  Thyroid/Other Glands  **Respiratory**  Bronchitis  Emphysema  Asthma  **Allergic/Immunologic**  Lupus  Drug Allergies  Environmental Allergies | **NO**                             | **YES**                             |

**If you answered yes** to any of the above, or have a condition not listed, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_