KATZEN
Eye Care & Laser Center

Patient Information

Date:_____(*PLEASE PRINT YOUR NAME AS IT APPEARS ON YOUR INSURANCE CARD)

Last: _____ First: _____ MI: _____

Local address: _____ Apt./Bldg. #_____

City: _____ State: _____ Zip: _____

Second address: _____

Date of birth: _____ - _____ - _____ Sex: _____ Male _____ Female

Marital status: (circle answer) Minor Married Single Separated Divorced Widow(er)

Social Security #: _____ - _____ - _____ Email address: _____

Preferred Phone #: (____) _____ - _____ Alternate phone #: (____) _____ - _____

Emergency contact name & phone #: _____ (____) _____ - _____

Occupation: _____ Place of Employment: _____

Language: _____ Race: _____ Ethnicity: _____

Referred by: (circle answer) Optometrist Ophthalmologist Physician TV Radio Internet Website Newspaper Insurance Family Friend

Name of Individual Referring: _____

HIPAA CONTACT LIST

Katzen Eye Care and Laser Center, its Associates and Staff have my permission to speak to the following family members/friends in reference to my medical care:

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

Katzen Eye Care and Laser Center, its Associates and Staff have my permission to leave a message on my home answering machine ____YES____ NO, and/or call me at my place of work (____) _____ - _____ ____YES____ NO

I have received and read a copy of the Notice of Privacy Practice of Katzen Eye Care and Laser Center.

X _____
Signature

MEDICAL HISTORY QUESTIONNAIRE

DATE: _____ **NAME:** _____ **D.O.B.:** _____
Primary Care Physician: _____ **Phone #:** _____
Cardiologist: _____ **Phone #:** _____
Endocrinologist: _____ **Phone #:** _____
PHARMACY NAME: _____
PHARMACY PHONE #: _____

PLEASE CIRCLE ALL THAT APPLY TO YOU:

Patient's past / present EYE history: Date of last exam: _____

NONE	Cataract	Flashes / floaters	Thyroid eye disease
Glasses / readers	Cataract surgery	Retinal tear / detachment	Dry / itchy / red / watery eyes
Contact lenses	High eye pressure	Retinal surgery / laser	Headache / Migraine
Corneal problems	Glaucoma / surgery	Macular degeneration	Styes / chalazion
Lazy eye	Glare / Halos	Eye injections	Blurry / cloudy vision
Muscle problems / surgery	Light sensitivity	Diabetic retinopathy	LASIK / PRK / Other

***Do you need a new eyeglass prescription? YES NO (PLEASE SEE REFRACTION INFORMATION FORM)**

Past Medical History: Date of Last Physical Exam: _____

NONE, good health	Irregular heart rate	Chemo therapy / radiation	Thyroid disease / Grave's
Diabetes	Asthma	Lupus	Kidney disease
Hypertension	Breathing trouble	Rheumatoid arthritis	Anxiety / Depression
Congestive heart failure	Emphysema	On Plaquenil	Mental illness _____
Bypass or stent	Auto immune disease	Dementia / Alzheimer's	MRSA (staph infection)
Pacemaker or Defibrillator	Cancer _____	Blood thinner use	Parkinson's
Stroke / TIA	Cancer Surgery _____	Other: _____	
High Cholesterol			

Do you smoke? ___YES ___NO How much?_____ Do you drink alcohol?___YES___ NO How much?_____

Do you use drugs? ___YES ___NO Explain: _____

Family History of eye disease and health problems:

NONE KNOWN	Keratoconus	Corneal problem	Retinal detachment
Glaucoma	Crossed eye	Amblyopia (lazy eye)	Macular degeneration
Blindness	Hypertension	Heart disease	Cancer: _____
Diabetes	Other: _____		

Review of systems: Do you presently have any problems in the following areas?

Ear, Nose, and or Throat	___ NO ___ YES	_____
Cardiovascular	___ NO ___ YES	_____
Respiratory	___ NO ___ YES	_____
Gastro-intestinal	___ NO ___ YES	_____
Urinary	___ NO ___ YES	_____
Skin	___ NO ___ YES	_____
Muscle	___ NO ___ YES	_____
Neurological	___ NO ___ YES	_____
Psychiatric	___ NO ___ YES	_____

DO NOT WRITE BELOW THIS LINE

Tech Signature _____ MD/OD Signature _____

KEC MEDICAL HISTORY RECORD

KATZEN EYE CARE & LASER CENTER

MEDICATIONS

PATIENT NAME _____ **DATE** _____

☐ **NONE**

MEDICATION NAME	STRENGTH/MG	ORAL/TOPICAL/INJ	FREQUENCY

ALLERGY INFORMATION – PLEASE LIST ALL ALLERGIES:

☐ **NO KNOWN DRUG ALLERGIES**

_____

_____

KATZEN
Eye Care & Laser Center

KATZEN EYE CARE AND LASER CENTER INSURANCE AND FINANCIAL

Primary Insurance Company: _____ **ID #:** _____

Insured Name: _____ **Insured D.O.B.:** _____

Secondary Insurance Company: _____ **ID #:** _____

Insured Name: _____ **Insured D.O.B.:** _____

PLEASE READ: YOU are responsible for payment in full at the time services are rendered.

ALL INSURANCE & LIFETIME MEDICARE B SIGNATURE AUTHORIZATION

FOR SERVICES STARTING DATE: _____

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration any information needed for this or a related Medicare 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.

Non-covered services: I understand that certain services including, but not limited to, normal eye exams, REFRACTIONS (determination of prescriptions for eyeglasses and contact lenses), contact lenses, supplies, letters and research are not covered by Medicare, most insurers, PPOs and prepaid health plans. I agree to pay for these services personally.

Covered services: I understand that almost all insurances, Medicare, PPOs and HMOs have a deductible and copayment which they do not cover. These deductibles and copayments are my direct responsibility and I will pay for these at the time services are rendered.

If it becomes necessary to effect collection of this account, I agree to pay all costs and expenses including designated attorney's fees.

I hereby verify that I have received the Notice of Privacy Practices.

PATIENT SIGNATURE: _____

REFRACTION AT KATZEN EYE CARE & LASER CENTER

WHAT IS A REFRACTION?

Refraction is the procedure or test that determines the best distance and reading vision your eyes can achieve, both with and without glasses or contacts.

WHY IS PERFORMING A REFRACTION NECESSARY?

Refraction is the first step in an evaluation of your eye health, especially if you are experiencing blurred or decreased vision.

If your vision is not 20/20, Refraction is needed to determine if you have a medical problem, or if you simply need a prescription for glasses.

Refraction is necessary to answer the following questions:
Is my current glasses prescription correct? Will new glasses help me see better?

Refraction is necessary to determine if cataract surgery is needed to improve your vision, or if your vision can be improved by just changing the corrective prescription for your glasses. The Refraction will document the medical necessity for cataract surgery and verify the need for coverage by insurance companies.

WHO PERFORMS THE REFRACTION?

We perform a refraction using any of several precise and highly technical instruments. The resulting information is evaluated by the expertise of our physicians and certified ophthalmic assistants.

DOES MY INSURANCE COVER THE COST OF THE REFRACTION?

NO. Medicare and most insurance companies **DO NOT** cover the charge for Refraction.

If you need the Refraction Test, a doctor or technician will notify you in advance, and you will have the chance to decline the service. However, you need to understand that if you decline, we may not be able to determine the cause for your decrease in vision.

The charge for the Refraction Test is $75.00; the fee is due when the service is rendered and covers the time, expertise, and effort in performing this procedure.

After performing the Refraction Test, we will give you a copy of your prescription, both for your records and to update your glasses if necessary.

We hope this helps you understand the reasons for the Refraction Test and the necessary charge. We are happy to answer any questions you may still have.

Acknowledgement:

I have read the above and understand that the Refraction Test is a non-covered service. If it is necessary, I accept full financial responsibility for the cost of the procedure.

Patient Signature_____ **Date**_____