Katzen Eye Care and Laser Center

Patient Information

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

WorkAddress: _____

Occupation: _____ Employer: _____

Sex: ____ SS#: _____ Email: _____

HIPPA 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 _____

_____ Relationship _____

_____ Relationship _____

Katzen Eye Care and Laser Center, it's associates and staff have my permission to leave a message on my home answering machine _____ YES _____ NO, and / or to call me at my place of work _____YES _____ NO

I have received a copy of the Notice of Privacy Practice of Katzen Eye Care and Laser Center _____ YES _____NO

Please turn over for Medical Information

Medical Information

Have you or a member of your family had:

Eye Surgery	**Y**	**N**	**explain:** _____
Eye Injury or Trauma	**Y**	**N**	**explain:** _____
Diabetes	**Y**	**N**	**explain:** _____
Autoimmune Problems	**Y**	**N**	**explain:** _____
Glaucoma	**Y**	**N**	**explain:** _____
Dry Eyes	**Y**	**N**	**explain:** _____
Glare/Halo @ night	**Y**	**N**	**explain:** _____
Keratoconus	**Y**	**N**	**explain:** _____

Do you have a history of an illness NOT listed above? Y N
If yes please specify: _____
_____

Please list any medications that you are presently taking: _____
_____
_____

Are you allergic to any medications? Y N
If yes please specify: _____

If female are you presently pregnant and/or nursing? Y N

Optometrist name: _____ **May we contact them: Y N**

In the event that medical care is required, unrelated to your refractive surgery
Your signature below will allow us to file a medical claim to your health insurance

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 to either myself or to the party who accepts assignments.

Non-covered services: I understand that certain services including, but not limited to, normal eye exams, refractions (determinations 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 co-payment which they do not cover. These deductibles and co-payments are my direct responsibility and I will pay for theses at the time the 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.

Patient Signature: _____

KATZEN
Eye Care & Laser Center
South Florida's Vision Correction Specialists

Patient Name: _____

I am here for: (please circle one)

LASIK or CATARACT or OTHER

I heard about Katzen Eye Care and Laser Center in **ALL** the following ways:

Please place a CHECK next to all the different ways you heard of Katzen Eye Care and Laser Center before you visit with us today. You may have SEVERAL checks on this page. Thank You.

RADIO

__95.5 Wild WLPI
__97.9 Variety WRMF
__107.9 Sunny Florida
__105.5 Kool
__98.7 The Gater

TV

__Cable TV
__Other TV

Online/Internet

__Google, Yelp, Healthgrades, Bing, etc
__Website – katzeneyecare.com
__Facebook

Newspaper

__Palm Beach Post
__Other print advertisement

Personal/Other

__Word of mouth_____name
__My Medical Doctor referral (Name_____)
__My insurance suggested Katzen Eye Care
__Other :_____(please describe)