Patient Name:

____

Please complete this form entirely.

I am here for: *(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 your visit with us today.
You may have SEVERAL checks on this page. Thank you.

RADIO

___94.3 WZZR REAL (Franny)
___95.5 Wild WLDI
___97.9 Variety WRMF
___101.3 South FL Country WIRK
___1290 AM WJNO Conservative Talk
___Radio (I cannot remember which station)

TV

___ Comcast Cable TV
___ Other TV

ONLINE/INTERNET

___I found you on Google, Bing, etc.
___I visited your website before my visit
___I saw you/visited your Facebook page before my visit

NEWSPAPER/PRINT

___Palm Beach Post
___Other print advertisement

PERSONAL/OTHER

___Word of Mouth
___My Medical Doctor referred me (Name: ________________)
___My Optometrist referred me (Name: ____________________)
___My insurance company suggested Katzen Eye Care and Laser Center
___Other: ______________________________
(Please describe)

For Office Use Only

__ Screen
__ Cons
___Sx

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 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