WELCOME TO OUR PRACTICE

KERRY SOLOMON, MD

Please fill out the following information completely:

1. Patient Information:

Social Security No:______________________ E-Mail Address:______________________

Name: (Last)______________________(First)______________(M.I.)__________

Address:____

City:______________________ State:__________Zip Code: __________

Home Phone:______________________ Cell Phone: ______________Consent to Text: Y / N

Date of Birth:______________________ Sex: M F Marital Status: S M D W

Preferred Language: ☐ English ☐ Spanish ☐ Other ______________________

Race: ☐ American Indian ☐ Alaska Native ☐ Asian ☐ African American ☐ Caucasian

☐ Native Hawaiian or other Pacific Islander ☐ Unknown ☐ Decline to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

Employed: ☐ No ☐ Full Time ☐ Part Time ☐ Retired Business Phone:______________________

Name of Employment or School: ____

2. Guarantor Information: Same as Above: ☐ Yes If patient is a minor please fill out.

Social Security No:______________________ E-Mail Address:______________________

Name: (Last)______________________(First)______________(M.I.)__________

Address:____

City:______________________ State:__________Zip Code: __________

Home Phone:______________________ Cell Phone: ______________________

Date of Birth:______________________ Sex: M F Marital Status: S M D W

Employed: ☐ No ☐ Full Time ☐ Part Time ☐ Retired Business Phone:______________________

Name of Employment or School: ____

3. Insurance Information:

Primary Insurance:______________________Policy #: ______________________

Insured's Name:______________DOB:__________Insured's SS# ______________________

Insured's Employment:______________________Work Phone: ______________________

Secondary Insurance:______________________Policy #: ______________________

Insured's Name:______________DOB:__________Insured's SS# ______________________

Insured's Employment:______________________Work Phone: ______________________

4. Appointment Information:

Family Doctor:______________________ Referring Doctor's Name:______________________

Who is your eye doctor? ____

How did you hear about us? ____

List any family members who are patients: ____

____

Emergency Contact:

Name:______________________Relationship:______________________Phone No: ______________

Pharmacy:

Pharmacy Name:______________________Pharmacy Location: ______________________

Pharmacy Phone: ______________________

KERRY SOLOMON, MD

Patient Name:____ DOB: _________________________

Eye History:

Have you experienced, are being treated for or been diagnosed with any of the following:

☐ Cataract ☐ Retinal Detachment ☐ Diabetes
☐ Glaucoma ☐ Dry Eyes ☐ Migraines
☐ Amblyopia ☐ Macular Degeneration ☐ Other: ________________________

Please explain the reason for your visit: ____
____

Have you ever experienced a serious eye injury or had eye surgery? ________________
Explain:____
Date of your last exam: ___________________________
Please list any eye drops or eye medications you are currently using: _______________________________________
____

Medical History:

Do you have any medication allergies? ________________
If so, please list: ____
Have you ever been diagnosed with any of the following?

☐ Asthma ☐ Cancer ☐ Heart Disease
☐ Stroke ☐ Arthritis ☐ Bleeding Disorder
☐ Thyroid ☐ High Blood Pressure ☐ Diabetes
☐ Mental Health Disorders (depression, anxiety etc.)

Please list your current medications and dosages:

_________________________ _________________________ _________________________
_________________________ _________________________ _________________________

Please list prior major surgeries: ____
Have you ever had a flu shot? ☐ Yes ☐ No
Have you ever had a pneumonia shot? ☐ Yes ☐ No

Family History:

Has anyone in your immediate family been diagnosed with any of the following?

☐ Glaucoma ☐ Heart Disease ☐ Macular Degeneration
☐ Cataract ☐ Diabetes ☐ Crossed or Lazy Eye
☐ Blindness ☐ Other _____________________

Social History:

Do you smoke? Yes / No If so, how many packs per day? __________
Has there been any change in your weight in the past 6 months? Yes / No Gain / Loss
Do you drink alcoholic beverages? Yes / No
If so, how much? Socially / With Meals / 2-3 Per Week / More _________________________________
Are you pregnant or planning? Yes / No
Your Occupation:______________________________________ How long: ____________________________
Reviewed with patient by:________________________________ On: _________________________________

KERRY SOLOMON, MD

Patient Name: ______________________________

Kindly complete this form to assist us in more fully understanding your goals and the present condition of your eyes.

What is your visual goal with Laser Vision Correction: (check all that apply)

☐ Reduce/eliminate distance correction ☐ Reduce/eliminate reading correction

What is your primary motivation to have Laser Vision Correction? ______________________________

____

What activity do you look most forward to doing without glasses or contacts? ______________________________

What hobbies or sports do you participate in? ______________________________

	Yes	No
1. Do you have dry eye problems? Circle one: Mild Moderate Severe	☐	☐
2. Do you have Migraines? If yes, list medication taking for Migraines ______________________________	☐	☐
3. Have you used ACUTANE in the last 6 month?	☐	☐
4. Do you have Diabetes or Thyroid Disease?	☐	☐
5. Have you ever been told you have keratoconus (corneal disease)?	☐	☐
6. Do you have collagen vascular, autoimmune or immunodeficiency disease? IE Rheumatoid Arthritis, Lupus, HIV/AIDS	☐	☐
7. Would you be satisfied if your vision was greatly improved even if you still had to wear corrective lenses some of the time?	☐	☐
8. Do you feel that good vision without glasses is more important than perfect vision?	☐	☐
9. Is it acceptable to you that you may need glasses for reading after LASIK/PRK?	☐	☐
10. Women: Are you Pregnant or Nursing?	☐	☐
Have you been bothered by:		
1. Night vision problems?	☐	☐
2. Seeing rings or halos around lights?	☐	☐
3. Glare caused by headlights or bright sunlight?	☐	☐
4. Any active eye disease or infection recently?	☐	☐
HAS YOUR PRESCRIPTION BEEN STABLE FOR 12 MONTHS?		
Do you use:		
Over the counter eye drops to treat Dry Eyes, Allergies or any eye problems?	☐	☐
Have you ever had:		
Any eye Surgeries? If yes, list surgeries ______________________________	☐	☐

If your prescription is -7.00 diopters or higher, a retinal evaluation is required prior to your procedure and is not covered in the cost of LASIK/PRK. If you have medical insurance and a medical diagnosis is confirmed by the retinal specialist, the charges can be billed to your insurance carrier. I understand that LASIK/PRK is a totally elective procedure and that I am under no obligation to undergo surgery at this time should I choose not to.

Patient Signature: ______________________________ Date: ______________

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

I understand your *Notice to Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Patient name:____DOB:___________________

Signature (of Patient or Legal Guardian): ____

Date: __________________________

*******I authorize the following to have access to my complete health records:**

____

PRACTICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgment of the Notice of Privacy Practices Acknowledgment but was unable to do so as documented below:

Date:	Initials:	Reason: