WELCOME TO OUR PRACTICE

Please fill out the following information completely:

KERRY SOLOMON, MD

1. Patient Information:

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

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
CAROLINA EYECARE PHYSICIANS

Patient Name: _____ DOB: _____

Eye History:

Have you experienced or been diagnosed with any of the following:

- ☐ Cataract
- ☐ Glaucoma
- ☐ Amblyopia
- ☐ Retinal Detachment
- ☐ Dry Eyes
- ☐ Macular Degeneration
- ☐ Diabetes
- ☐ Migraines
- ☐ Other _____

Please describe 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
- ☐ Stroke
- ☐ Thyroid
- ☐ Cancer
- ☐ Arthritis
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Bleeding Disorder
- ☐ Diabetes

Please list your current medications and dosages:

_____ _____ _____

_____ _____ _____

Please list prior major surgeries: _____

Family History:

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

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

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
CAROLINA EYECARE PHYSICIANS

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 primary motivation to have Laser Vision Correction? _____

_____

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 _____	☐	☐

A retinal examination will be necessary before proceeding with LASIK surgery if your prescription is -7 diopters or more. This retinal evaluation is not covered or included in the cost of your LASIK procedure. However, it can be billed to your insurance company. I understand that LASIK/PRK surgery is a totally elective procedure and that I am under no obligation to undergo surgery at this time should I choose not to. ☐ **Yes** ☐ **No**

Patient Signature: _____ Date: _____

KERRY SOLOMON, MD
CAROLINA EYECARE PHYSICIANS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

WHAT IS THIS NOTICE ABOUT AND WHY IS IT IMPORTANT?

This notice is required by the U. S. Department of Health and Human Services in order for me to be informed of how my health information will be used, disclosed, and protected, and about my rights regarding my health information. I understand that under the Health Insurance Portability and 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:

- **For Treatment:** We are permitted to use your health information or disclose it to others outside Carolina Eyecare Physicians, LLC in order to provide, plan and direct proper medical care for you.
- **For Payment:** We are permitted to disclose health information about your treatment and services in order to submit bills for the care and services you received, and collect payment from you, your insurance company or a third party payer.
- **For Health Care Operations:** We are permitted to use your heal th information to assess the care and the outcome in your case and others like it, in order to assure the highest quality of care for our patients.

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 is available to me. 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.**

◊ ◊ ◊ I DO authorize / I DO NOT authorize Carolina Eyecare Physicians, LLC to release my protected health information to family members. ◊ ◊ ◊
(Please circle one)

Patient name: _____ DOB: _____

Signature (of Patient or Legal Guardian): _____

Date: _____

Practice Use Only

I attempted to obtain the signature of the patient or legal guardian in acceptance of the Notice Of Privacy Practices Acknowledgment but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

_____