WELCOME TO KLINE VISION INC.

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip

Sex: ☐ M ☐ F Age _____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

_____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

Email Address: _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____

Subscriber Address _____

_____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Kris, Kline, O.D., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

3 PHONE NUMBERS

Home: _____ Work: _____ Ext.: _____

Cell Phone: _____ Spouse's Work: _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

4 EYE HEALTH HISTORY

Medical Doctor _____

Date of last visit _____

Eye Doctor _____

Date of last visit? _____

Do you wear glasses? ☐ Yes ☐ No

☐ All the time ☐ Occasionally

☐ Reading ☐ Driving ☐ TV

Do you wear contacts? ☐ Yes ☐ No

Type _____ Hours/Day _____

Describe any problems you have with your contacts

_____

_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bloodshot Eyes	☐ Yes ☐ No	Floaters or Spots	☐ Yes ☐ No	
Blurred Vision -Distance	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	
Blurred Vision -Near	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	
Burning Eyes	☐ Yes ☐ No	Itching Eyes	☐ Yes ☐ No	
Cataracts	☐ Yes ☐ No	Light Sensitive	☐ Yes ☐ No	
Color Vision, Poor	☐ Yes ☐ No	Loss of Vision	☐ Yes ☐ No	
Crossed Eyes	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	
Discharge from Eyes	☐ Yes ☐ No	Night Vision, Poor	☐ Yes ☐ No	
Dizzy Spells	☐ Yes ☐ No	Red Eyes	☐ Yes ☐ No	
Double Vision	☐ Yes ☐ No	Seeing Halos	☐ Yes ☐ No	
Dry Eyes	☐ Yes ☐ No	Seeing Flashes	☐ Yes ☐ No	
Eye Infection	☐ Yes ☐ No	Temporary Loss of Vision	☐ Yes ☐ No	
Eye Injury	☐ Yes ☐ No	Twitching Eyelid	☐ Yes ☐ No	
Eye Strain	☐ Yes ☐ No	Vision Poor	☐ Yes ☐ No	
Fainting Spells, Blackouts	☐ Yes ☐ No	Watering Eyes	☐ Yes ☐ No	

-OVER-

5 HEALTH HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself	Family Members
AIDS/HIV	☐ Yes ☐ No	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	☐ Yes ☐ No
Bleeding	☐ Yes ☐ No	☐ Yes ☐ No
Blindness	☐ Yes ☐ No	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No
Drug Sensitivity	☐ Yes ☐ No	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	☐ Yes ☐ No
Eye Surgery	☐ Yes ☐ No	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No
Hay Fever	☐ Yes ☐ No	☐ Yes ☐ No
Heart Condition	☐ Yes ☐ No	☐ Yes ☐ No

	Yourself	Family Members
Hepatitis (Type)	☐ Yes ☐ No	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No	☐ Yes ☐ No
Lazy Eye	☐ Yes ☐ No	☐ Yes ☐ No
Lupus	☐ Yes ☐ No	☐ Yes ☐ No
Migraine Headaches	☐ Yes ☐ No	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	☐ Yes ☐ No
Poor Color Vision	☐ Yes ☐ No	☐ Yes ☐ No
Retinal Disease	☐ Yes ☐ No	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	☐ Yes ☐ No
Shingles	☐ Yes ☐ No	☐ Yes ☐ No
Skin Conditions	☐ Yes ☐ No	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	☐ Yes ☐ No
Thyroid Conditions	☐ Yes ☐ No	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	☐ Yes ☐ No
Turned Eye	☐ Yes ☐ No	☐ Yes ☐ No

Are you pregnant? _____ Number of children _____

Tobacco use _____ Alcohol use _____

MEDICATIONS

List medications you are currently taking, including eye drops:

_____

_____

_____

_____

Pharmacy name _____

Phone _____

ALLERGIES

List your allergies to medications or other substances:

_____

_____

_____

_____

_____

_____

I consent to a dilated exam today and I understand my vision will be blurry. _____ I refuse. _____

Physician signature _____

6 MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished to me by that doctor. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge termination of the Medicare carrier. Medicare does not cover routine exams or refractions.

_____ _____

Signature of Beneficiary Date