

For Our Established Patients



Return Visits to Kilgore Vision Center

This packet is provided to help you prepare for your return visit to us. Please take a moment to fill out all information included so we will be able to expedite your check-in process. You may complete these forms electronically and print, or print and complete by hand.

Inside this packet you will find:

- Patient Registration Form- please update all information.
- Patient Medical History and Questionnaire- these are updated annually
- Patient Privacy Questionnaire
- Activities of Daily Living Questionnaire

If you have any questions, feel free to speak with one of our friendly staff members by calling us at (800) 844-4904.

Remember to bring your current medications and your insurance cards to each visit.

We look forward to serving you!



2943 Hwy. 62 West, PO Box 444 • Mountain Home, Arkansas 72654
(870) 424-4900

105 Sawgrass Point • Harrison, Arkansas 72601
(870) 741-1910

Toll Free (800) 844-4904

Patient Registration Form



Name: _____ Male Female Age: _____ Birthdate: _____

Address: _____
Street City State Zip

Marital Status: _____ Social Security No: _____ Home Phone (____) _____

Employer: _____ Work Phone (____) _____

Responsible Party: _____ Home Phone (____) _____

Address: _____
Street City State Zip

Employer: _____ Work Phone (____) _____

Emergency Contact: _____ Relationship: _____

Contact's Home Phone: (____) _____ Contact's Work Phone: (____) _____

Past Eye Problems: _____

Current Eye Problems: _____

Insurance Information

Primary

Insurance Company: _____

Insured Name: _____

Insured Date of Birth: _____

Policy Number: _____

Secondary

Insurance Company: _____

Insured Name: _____

Insured Date of Birth: _____

Policy Number: _____

Assignment and Release

I, the undersigned, have insurance coverage with, _____ and assign directly to Kilgore Vision Center all medical benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize this facility to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian

Date

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Kilgore Vision Center for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized 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 non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Signature of Insured/Guardian

Date

Form 418/Revised 10-08

Review of Systems



Date: _____ Name: _____ Account # _____

(To be completed by patient)

SOCIAL HISTORY

Do you drive? No Yes If yes, do you have visual difficulty when driving? No Yes

If yes, please describe: _____

Do you use tobacco products? No Yes If yes, type /amount / how long: _____

Do you drink alcohol? No Yes If yes, type/ amount / how long: _____

Do you use illegal drugs? No Yes If yes, type/ amount / how long: _____

Have you ever been exposed to or infected with: Hepatitis HIV Gonorrhea Syphilis None

REVIEW OF SYSTEMS

Do you currently have or ever had any problems in the following areas? If yes, please explain.

	Yes	No	
Constitutional: Fever, Weight Loss/Gain			
Eyes: Cataracts, Lazy Eye, Glaucoma, Macular Degeneration, Blurry Vision, Dry Eyes, Other			
Ear, Nose Throat & Mouth: Congestion, Dry Mouth/Throat, Runny nose, Cough			
Respiratory: Asthma, Emphysema, Bronchitis, Sleep Apnea			
Vascular: Diabetes, High Blood Pressure, Vascular Disease, High Cholesterol			
Heart Problems: CAD, Heart Attack, Heart Pain			
Gastrointestinal: Diarrhea, Constipation			
Genitourinary: Kidney, Bladder, Genitals			
Bones, Joints & Muscles: Rheumatoid Arthritis, Joint Pain, Muscle Aches, Arthritis			
Lymphatic/Hematological: Anemia, Bleeding			
Endocrine: Thyroid, other glands			
Neurological: Headaches, Migraines, Seizures			
Psychiatric: Anxiety, Depression			
Skin: Lesions, Rashes, Redness, Discolored Moles			
Allergic/Immunologic			

FAMILY HISTORY

	No	Yes	?	Relationship	No	Yes	?	Relationship
Blindness								Cancer
Cataract								Diabetes
Crossed Eyes								Heart Disease
Glaucoma								High Blood Pressure
Macular Degeneration								Kidney Disease
Retinal Detachment								Lupus
Other Eye Disease:								Rheumatoid Arthritis
Other:								Thyroid Disease

Form 101B/Revised 10/08

Patient Privacy Questionnaire



Patient's Name: _____ Chart # _____

Please list the family member(s) or other persons, if any, whom we may inform about your eye medical condition and your diagnosis (including treatment, payment and health care options):

Person's Name Relationship to Patient

Person's Name Relationship to Patient

Person's Name Relationship to Patient

Person's Name Relationship to Patient

Please print the address of where you would like your billing statements and/or correspondence from our office sent, **if other than your home:**

Street Address City State/Zip

Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other eye care information, **if other than your home telephone:**

Phone number: (____) _____

I am fully aware that a cell phone is not a secure and private line. _____
Signature

Can confidential messages (i.e. appointment reminders) be left on your answering machine or voicemail?

Yes No

Signature of Patient or Guardian Date

Form 417/Revised 10-08

ADL Questionnaire



Name: _____ Chart # _____ Date: _____

Reason for exam today (in patient's words): _____

What specific improvements in your daily life do you hope to gain with surgery? _____

Visual Function Status

1. Do you have **difficulty** seeing street signs or to drive?
(such as curbs, freeway exits, traffic lights, or halos and glare around lights) Yes NO
2. Do you have **difficulty** seeing movies or the television?
(such as the faces, numbers, or printing on the screen) Yes NO
3. Do you have **difficulty** reading small print with good light and proper glasses?
(such as a telephone book, newspaper, book, medicine labels, instructions) Yes NO
4. Do you have **difficulty** performing handiwork?
(such as sewing, knitting, crocheting embroidery, or other fine tasks) Yes NO
5. Do you have **difficulty** with personal correspondence?
(such as writing checks, reading bills, filling out forms) Yes NO
6. Do you have **difficulty** with leisure activities?
(such as playing card games, bingo, dominoes, or sport activities like golfing,
hunting, tennis, or bowling) Yes NO
7. Do you have visual **difficulty** with navigation around the house?
(such as cooking, climbing steps or curbs, dialing the phone, or reading a wrist watch) Yes NO
8. Are you **able** to see and recognize the faces of people from a distance?
(such as people at church, the grocery store, and clubs) Yes NO
9. Are you **able** to care for yourself with your present vision? Do you live alone
and wish to remain independent? Yes NO

Do you have any of the following visual symptoms?

- | | | | |
|------------------------------------|--|-----------------------------------|--|
| Double or distorted vision? | <input type="checkbox"/> Yes <input type="checkbox"/> NO | Difficulty with depth perception? | <input type="checkbox"/> Yes <input type="checkbox"/> NO |
| Glare, halos, rings around lights? | <input type="checkbox"/> Yes <input type="checkbox"/> NO | Worsening/blurred vision? | <input type="checkbox"/> Yes <input type="checkbox"/> NO |
| Difficulty with color perception? | <input type="checkbox"/> Yes <input type="checkbox"/> NO | | |

Signature of Patient

Date

Form 456/Revised 10/08