

***For Our New Patients***



***Welcome to Kilgore Vision Center!***

This packet is provided to help you prepare for your upcoming visit with us. Please take a moment to fill out all information included so that we may better serve you.

**Inside this packet you will find:**

- Welcome letter with helpful tips and information
- Patient Registration Form
- Patient Medical History and Questionnaire
- Notice of Privacy Practices
- 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

# New Patient Information



Today's Date: \_\_\_\_\_ Your Appointment is scheduled: \_\_\_\_\_ at \_\_\_\_\_

Dear Patient,

Welcome to Kilgore Vision Center. We look forward to providing you with the most advanced eye care available in a friendly and caring atmosphere.

In order to lessen your wait time before your examination, **please complete the enclosed forms and bring them with you for your appointment:**

- Patient Registration Form
- Patient Medical History and Questionnaire
- Notice of Privacy Practices

## **Please remember to bring:**

- Your current medications you are taking
- Any eye medications you are taking
- Insurance cards
- A referral, if it is required by your insurance company

## **If you are a new patient to Kilgore Vision Center:**

- Plan to spend approximately 1-2 hours with us. This time may vary according to test being performed.
- Your eyes may be dilated. Please bring a companion with you to drive you home, if needed.

## **Financial Responsibility:**

You are responsible for any unmet deductibles and/or co-payments at the end of your visit. If you have any questions, please do not hesitate to call and speak with one of our patient service representatives or patient account representatives. We look forward to seeing you and providing you with your medical and optometry needs.

Kilgore Vision Center

# 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				
<b>Other:</b>				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

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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

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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

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\_\_\_\_\_  
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