KORBER EYECARE
& SURGERY CENTER

David Korber
3301 NW 63rd Street
Oklahoma City, OK 73116

Patient Information

Last Name: _____ MI:_____ First Name:_____

SS#: _____ Date of Birth:_____ Age:_____

Driver's License#: _____ Sex (☐M /☐ F)

Marital Status: ☐S ☐M ☐W ☐Sep. ☐D Email Address:_____

Home Ph#:_____ Work #:_____ Cell #:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Employer/Co:_____ Job Title:_____

Referred by: _____

Emergency Contact:_____ Relationship:_____

Phone # (s):_____

Insurance Information

Primary Insurance Carrier: _____

Insured's Name:_____ Sex (☐M / ☐F)

Insured's SS#:_____ Insured's DOB:_____ Group Insurance (☐Y / ☐N)

Relationship to Patient:_____

Secondary Insurance Carrier:_____

Insured's Name:_____ Sex (☐M / ☐F)

Insured's SS#:_____ Insured's DOB:_____ Group Insurance (☐Y / ☐N)

Relationship to Patient:_____

Responsible Party Information (if not patient)

Name:_____ Relationship:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone #(s):_____

Please read and sign below.

I authorize any holder of medical or other information about me to release to be released to the Social Security Administration and Health Care Financial Administration or its intermediaries or carriers of any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either myself or to the party who accepts assignments. Regulations pertaining to Medicare assignment of benefits apply. I understand that the authorization of this release of information for the purpose of processing my insurance claim may contain reference to, or the result of HIV Antibody (AIDS) testing.

Signature:_____ **Date:**_____

Patient History Form Patient Name:_____ Date:_____

Reasons for today's visit:_____

Your Past Eye History:

Y	N		Y	N	
☐	☐	Glaucoma	☐	☐	Blindness
☐	☐	Cataracts	☐	☐	Trauma
☐	☐	Macular Degeneration	☐	☐	Retinal Detachment
☐	☐	Color Blindness	☐	☐	Lazy Eye

Family Eye History:

Y	N		Y	N	
☐	☐	Glaucoma	☐	☐	Blindness
☐	☐	Cataracts	☐	☐	Trauma
☐	☐	Macular Degeneration	☐	☐	Retinal Detachment
☐	☐	Color Blindness	☐	☐	Lazy Eye

Your Medical History:

Y	N		Y	N	
☐	☐	Heart Surgery or Attack (circle one)	☐	☐	High Blood Pressure
☐	☐	Blood-borne Disease: _____	☐	☐	High Cholesterol
☐	☐	Hyper or Hypothyroid (circle one)	☐	☐	Neurological (M.S., Alzheimer's, etc.)
☐	☐	Asthma or Emphysema (circle one)	☐	☐	Skin (Psoriasis, cancer, eczema, etc.)
☐	☐	Back Problems	☐	☐	Gastrointestinal problems
☐	☐	Lupus or Collagen Disease (circle one)	☐	☐	Bleeding disorders
☐	☐	Kidney problems or failure	☐	☐	Diabetes, Date Diagnosed:_____
☐	☐	Oxygen / Liters:_____	☐	☐	Stroke, Dates:_____
☐	☐	Depression or anxiety (circle one)	☐	☐	Cancer, Type:_____

Your Social History:

Y	N		Y	N	
☐	☐	Drug Use	☐	☐	Tobacco Use
☐	☐	Alcohol Consumption	☐	☐	Computer Use

Current Medications:

Y	N		Y	N	
☐	☐	Eliquis (Apixaban)	☐	☐	Flomax (Tamsulosin)
☐	☐	Plaquenil (Hydroxychloroquine)	☐	☐	Prednisone
☐	☐	Coumadin (Warfarin)	☐	☐	Cordarone (Amniodarone)
☐	☐	Aspirin	☐	☐	Anti-psychotic medication

Please list ALL medications (eye medications first):

_____

_____

Latex Allergy: **Y** ☐ **N** ☐ **Drug Allergies:** **Y** ☐ **N** ☐ If yes, please list:_____

_____

Surgeries: Eye Surgeries: **Y** ☐ **N** ☐ Other Surgeries **Y** ☐ **N** ☐

Please list procedures, doctors & approximate dates:_____

_____

_____

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Acknowledgment of Receipt of Notice of Privacy Practices and Consent
For Treatment, Payment and Healthcare Operations

PATIENT NAME_____

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called "PROTECTIVE HEALTH INFORMATION" (PHI) under a federal health privacy law. I further understand and agree that in this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke this authorization in writing.

I understand and have reviewed the PATIENT PRIVACY NOTICE that provides a more complete description of information uses and disclosure prior to signing this consent. I understand that Korber EyeCare reserves the right to change this notice and practices. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Korber EyeCare is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent that Korber EyeCare has already taken action in reliance thereon.

BY OKLAHOMA LAW, we are required to notify you… that the information authorized for release may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS):

Information may be released to the following individuals/organizations for the indicted purpose:
(you may list to whom in the family we may talk to).

1. Name:_____ Phone #_____

2. Name:_____ Phone #_____

Please check the following questions yes or no

Can we leave appointment reminders on your answering machine? **Y** ☐ **N** ☐
Can we leave medical information on your answering machine? **Y** ☐ **N** ☐
Can we mail a postal card appointment reminder to your address? **Y** ☐ **N** ☐

By signing below, you also provide your consent for Korber EyeCare and its providers to electronically submit your prescriptions through an e-prescribing system and to request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

Please list your primary pharmacy:

Name of Pharmacy: _____

Street Address:_____

City:_____ State:_____ Zip:_____

Phone Number:_____

PLEASE SIGN THIS AUTHORIZATION

_____ _____
Signature of Patient or Legal Representative Date Notice Effective

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits.