Michael J. Atteberry O.D., Whitney Coleman O.D.
3201 S Iowa St., Lawrence, KS 66046 (785) 841-2020

Name: (First, M.I., Last)_____ *Sex:* ***M / F*** **Date of Birth: _____**
Race (circle): Native American, African American/Black, Asian, Pacific Islander, White, Hispanic/Latino, Other
BILLING Address: _____
City:_____ State: _____ Zip:_____
Residential Address (IF different):_____
City:_____ State: _____ Zip:_____
Phone: (Home):_____ (Work):_____ (Cell/Text):_____
Email Address: _____Employer/Occupation: _____
Please circle your preferred method of contact: phone call, text message, email or mail
Do we have permission to send you text message reminders for future appointments? □ yes or □ no
SSN: _____ Emergency Contact: _____ Phone: _____
Last Medical Exam: _____ Primary Care Doctor: _____
Last Vision Exam:_____ Previous Eye Doctor: _____

Insurance Co.:_____ ID #:_____Group#_____
*****SKIP this section if you have presented your insurance card(s) to us*****
Name of primary insurance holder:_____ Date of Birth:_____
Phone: _____ Relationship to patient: _____ Employer: _____
Address: _____ City: _____ State: _____ Zip: _____

Medical History Weight:_____ Height:_____
List any medication allergies and describe your reaction:_____
_____
List any medications you are currently taking (including over the counter, home remedies, and contraception):
_____
_____
List major surgeries, illnesses, or injuries: _____
_____
Please check if you have ever been exposed to or infected with: Hepatitis: □ HIV: □ Neither: □
Are you pregnant and/or nursing? Yes: □ No: □
Please list any occupational hazards: _____
Please check if you currently, or have ever had any problems in the following areas:

Constitutional:		Chronic bronchitis:	□	**Gastrointestinal**:	
Weight loss/gain:	□	Emphysema:	□	IBS/Crohn's Disease	□
Fever:	□	**Vascular/Cardiovascular**:		**Endocrine**:	
Lymphatic/hematologic:		Diabetes:	□	Thyroid:	□
Anemia/bleeding:	□	Stroke:	□	Other glands:	□
Ear/nose/mouth/throat:		High blood pressure:	□	**Bones/Joints/Muscles**:	
Allergies/hay fever	□	Heart condition:	□	Arthritis:	□
Sinus congestion:	□	**Integumentary (skin)**:		Muscle pain:	□
Chronic cough:	□	Eczema	□	Joint pain:	□
Dry throat/mouth:	□	Psoriasis	□	**Neurological:**	
Respiratory:		**Allergic/immunology**	□	Headaches:	□
Asthma:	□	**Psychiatric**:	□	Migraines:	□

If you have checked any of the above or have a condition not listed, please explain and list any treatment:
_____
_____

**** Please turn this form over and complete the other side **(*office use only PD__Scan__)***

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Eye History:

Please check if you currently, or have ever had any of the following conditions:

Cataract:	□	Dry eyes:	□	Eye infections:	□
Glaucoma:	□	Redness:	□	Crossed eyes:	□
Macular degeneration:	□	Itching/burning:	□	Lazy eye:	□
Loss of vision:	□	Discharge/watering:	□	Flashes/floaters:	□
Blurred vision:	□	Pain/soreness:	□	Halos/Glare:	□
Double vision:	□	Sties/chalazion:	□	Light sensitivity:	□

List any eye diseases, injuries, or surgeries:_____
Do you wear glasses? Yes: □ No: □ If yes, how old is your current pair? _____
Do you wear contacts? Yes: □ No: □ If yes, what brand? _____
Contact lens solution type: _____ How often do you replace your contact lenses?:_____

Family History:

Please note family history of the following using these abbreviations: M= Mother, F= Father, S= Sibling, GP= Grandparent

□ Blindness: _____	□ Crossed eyes: _____	□ Lupus: _____
□ Cataract: _____	□ Diabetes: _____	□ Thyroid disease: _____
□ Glaucoma: _____	□ High blood pressure: _____	□ Arthritis: _____
□ Macular degeneration: _____	□ Heart disease: _____	□ Kidney disease: _____
□ Retinal disease: _____	□ Cancer: _____	□ Other: _____

Social History:

Do you drive? Yes: □ No: □ If yes, do you have visual difficulty when driving? Yes: □ No: □ If yes, please describe: _____
_____

Check the box next to the statement that best describes your tobacco use:

□ Current every day smoker □ Never smoked □ Current smokeless tobacco user
□ Current some day smoker □ Former smoker

Check the box next to the statement that best describes your alcohol use:

□ None □ 1-2 drinks daily □ Alcohol dependence
□ Social use only □ Above average use

Check the box next to the statement that best describes your narcotic use:

□ None □ Recreational use □ Chemical dependence

Please initial after each of the following statements and then sign at the bottom of this page:

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our offices. We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this consent. If you sign this authorization, you can revoke it at any time. You may not retroactively retract consent of the release of protected health information. We can elect to decline service to you if you choose not to sign this consent form. _____

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby authorize directly to Atteberry Eye Center including physicians associated herewith, the benefits payable under all plans of accident, health and optical insurance otherwise payable to me, not to exceed the physician's charges for the period of treatment. I further understand that insurance policies are an arrangement between my insurance carriers and me, and that I am personally responsible for all bills incurred at this office. I understand that if the bill is not paid in full, in a reasonable time frame, I will be obligated to pay reasonable cost of collections, including but not limited to, collections fees, court cost, attorney fees, and collection agency's fees. _____

AUTHORIZATION TO TREAT A MINOR: I hereby authorize Dr. Michael J. Atteberry, O.D. and whomever he may designate as his assistants to administer treatment as deemed necessary to the minor child. _____

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described in this form. Please sign in front of an office staff member. Thank you.

_____ _____
Signature of patient or parent/guardian Date

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Atteberry Eye Centers, LLC make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that (**SELECT <u>ONE</u> OF THE FOLLOWING**):

- ☐ **(I DO want to read the HIPPA policy NOW!)** I have read or had explained to me Atteberry Eye Centers, LLC's Notice of Privacy Practice and agree to continue my care with Atteberry Eye Centers under said terms.
- ☐ **(I do NOT want to read the HIPPA policy!)** I was given to opportunity to read Atteberry Eye Centers, LLC's Notice of Privacy Practices and declined but wish to continue my care with Atteberry Eye Centers, LLC under the terms of Atteberry Eye Centers, LLC's privacy policies.
- ☐ I have read or had explained to me Atteberry Eye Centers, LLC's Notice of Privacy Practice and **<u>do not</u>** wish to continue my care with Atteberry Eye Centers, LLC under said terms.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

  _____
  _____
- ☐ I have read or had explained to me Atteberry Eye Centers, LLC's Notice of Privacy Practice for Health Information Exchange

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____
Representative Relationship to Patient