ATTEBERRY EYE CENTERS

PATIENT REGISTRATION

Patient Information	(Select preferred contact method)
First Name _____	☐ Cell # _____
Last Name _____	☐ Home # _____
Middle Initial _____ Gender _____	☐ Work # _____
Date of Brith _____ SSN _____	☐ E-Mail _____
Address _____	Occupation _____
Suite/Apt. _____	Employer/School _____
City _____ State _____ Zip _____	

Do we have permission to send you text message reminders for future appointments? ☐ yes ☐ no

Race

☐ American Indian or Alaskan Native ☐ Black or African American ☐ White or Caucasian ☐ Hispanic or Latino ☐ Asian
☐ Native Hawaiian or Other Pacific Islander ☐ Other _____

Emergency Contact

Name _____ Phone _____

Insurance Policy Holder Information ***SKIP*** *this section if you have already presented your insurance card to us*	
Medical Insurance _____	Vision Insurance _____
ID # _____ Group # _____	ID # _____ Group # _____
Policy Holder's Name _____	Policy Holder's Name _____
Date of Birth _____ SSN _____	Date of Birth _____ SSN _____
Relationship to Patient _____	Relationship to Patient _____
Employer _____	Employer _____
Street Address _____	Street Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____

Reason for Visit	**Where did you hear about our office?**
Date of Last Eye Exam _____	☐ Referred by Primary Care Physician
Former Optometrist _____	☐ Visited our Website
Main reason for visit: ☐ Annual Exam ☐ Diabetic ☐ Glasses	☐ Social Media
☐ Contacts ☐ Medical Concerns ☐ Other _____	☐ Referred by _____
	☐ Other _____

Social History

Do you use tobacco products ☐ Yes ☐ No | **If Yes** ☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker
☐ Current chewing tobacco user ☐ Current Vape tobacco user

Do you drink alcohol ☐ Yes ☐ No | **If Yes** ☐ Social use only ☐ 1-2 drinks daily ☐ Above average ☐ Alcohol dependence

Office Use Only: REV _____ SCAN _____

Ocular History (Please select all that apply)			
☐ Cataract	☐ Floaters/Flashes	☐ Tearing	☐ Headaches
☐ Macular Degeneration	☐ Iritis/Uveitis	☐ Discharge	☐ Poor Night Vision
☐ Glaucoma	☐ Retinal Defects	☐ Blurred Vision	☐ Night Glare
☐ Diabetic Retinopathy	☐ Redness	☐ Eyestrain	☐ Double Vision
☐ Dry Eye	☐ Burning	☐ Eye Pain	☐ Styes
☐ Eye Infection/Allergy	☐ Itching	☐ Light Sensitivity	☐ Total Vision Loss

Contact Lens *SKIP this section if you DO NOT wear contact lenses*		
Contact Lens Brand _____	**Current lens age**	Avg. daily wearing time _____ min/hr
Contact Lens Solution _____	_____ Day/Week/Month	Today's wearing time ____ min/hr/day
Drops used _____	**Lenses remaining**	Avg. replacement ____ day/week/month
Additional Comments _____	_____ Lens/Box	Overnight Wear ☐ yes ☐ no

General Medical History (Please select all that apply)

Constitutional
☐ Development Disability
☐ Cancer
☐ Fatigue Syndrome

Ear/Nose/Mouth/Throat
☐ Hearing Loss
☐ Sinus Congestion
☐ Dry throat/Mouth
☐ Upper Resp Infection

Neurological
☐ Multiple Sclerosis
☐ Seizures
☐ Tumor
☐ Migraines
☐ Autism

Psychiatric
☐ Depression
☐ Attention Deficit
☐ Anxiety
☐ Bipolar Disorder

Cardiovascular
☐ High Blood Pressure
☐ Stroke
☐ Heart Disease

Respiratory
☐ Asthma
☐ Chronic Bronchitis
☐ Emphysema
☐ COPD
☐ Sleep Apnea

Gastrointestinal
☐ IBS/Crohn's Disease
☐ Colitis
☐ Ulcer
☐ Acid Reflux
☐ Celiac Disease

Genitourinary
☐ Kidney Disease
☐ Prostate Disease
☐ STD
☐ Prostate Issue
☐ Pregnant/Nursing

Muscles/Bones/Joints
☐ Osteoarthritis
☐ Arthritis
☐ Fibromyalgia
☐ Muscular Dystrophy
☐ Osteoporosis
☐ Gout

Integumentary (skin)
☐ Eczema
☐ Rosacea
☐ Psoriasis
☐ Cold Sores
☐ Shingles

Endocrine
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ Thyroid
☐ Hormonal Dysfunction

Hematologist/Lymphatic
☐ Anemia
☐ Ulcer
☐ High Cholesterol

Allergic/Immunologic
☐ Allergies/Hay Fever
☐ Rheumatoid Arthritis
☐ Lupus

Medications _____
_____
_____
_____
_____

Drug Allergies _____
_____
_____

Have you ever been exposed or infected with ☐ HIV ☐ Hepatitis

Primary Care Physician: _____

Date of Last Exam: _____

Family History (Please select all that apply to your: M=Mother, F=Father, B=Brother, S=Sister, G=Grandparent)			
☐ Arthritis _____	☐ Hypertension _____	☐ Blindness _____	☐ Retinal Disease _____
☐ Cancer _____	☐ Kidney Disease _____	☐ Cataract _____	☐ Crossed Eyes _____
☐ Diabetes _____	☐ Lupus _____	☐ Glaucoma _____	☐ Strabismus _____
☐ Heart Disease _____	☐ Thyroid Disorder _____	☐ Macular Degen _____	☐ Other _____

atteberryeyecenters@gmail.com
2144 SW 36TH Street Topeka, KS 66611 | P: 785.266.1010 | F: 785.266.5312
5100 Bob Billings Parkway #100 Lawrence, KS 66049 | P: 785.841.2020 | F: 785.841.0420

ATTEBERRY
EYE CENTERS

PATIENT REGISTRATION

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

AUTHORIZATION TO TREAT: **This gives us permission to provide treatment and to share your protected health information as necessary when we refer you to other providers, such as a specialist for a surgical consult. **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 fully details these uses and disclosures. You are free to refer to this notice at any time before you sign this consent. If you sign this authorization, you may revoke it at any time. You may not retroactively retract consent of the release of protected health information. We will elect to decline service if you choose not to sign this consent form. _____

AUTHORIZATION TO PAY INSURANCE BENEFITS: **This gives us permission to file your insurance claim for you, and to share your protected health information as necessary in order to prove your claim valid. If you do not want us to do this, you can pay your balance up front and submit your claim on your own. **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: **This gives us permission to treat the minor child in your charge. ** I hereby affirm that I have legal authority to seek treatment for this minor, and authorize Dr. Michael J. Atteberry, O.D., Dr. Kathryn McCampbell, O.D., Michael Malone, O.D. Stacy Fitch O.D., Kimberly Pearl O.D., Heather Polson O.D., and/or 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 Relationship to Patient 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 ONE OF THE FOLLOWING):

☐ (I DO want to read the HIPAA policy) 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 HIPAA policy) I was given the 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.

☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care or other reason described as:

☐ I have read or had explained to me Atteberry Eye Centers, LLC's Notice of Privacy Practice and do not wish to continue my care with Atteberry Eye Centers, LLC under said terms.

The Following person(s) are authorized to speak with you on my behalf:

(Skip if not applicable): _____

_____

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

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