

Welcome to R. Kevin Lenahan Optometrist & Assoc.

Please fill out the following information. This information is kept strictly confidential.

Name (first, mi, last) _____ Sex F / M Today's date ___/___/___
 Address _____ City _____ State _____ Zip _____
 Phone # (____) _____ Birth date ___/___/___ Age _____ SS# _____
 Employer _____ Work # (____) _____
 E-mail address _____ @ _____ Occupation _____ Spouse _____
 Last medical exam ___/___/___ Dr. Name _____ Last vision exam ___/___/___
 Insurance Co. _____ ID# _____ Group# _____

Name of responsible party _____	Birth date ___/___/___
SS# _____	Phone# (____) _____
E-mail address _____	@ _____
Address _____	City _____
State _____	Zip _____
Employer _____	Work# (____) _____
Relationship to patient _____	

Medical History

List any medication allergies _____

List medications you are taking (including over the counter, home remedies and contraceptives) _____

List major surgeries, illness, and/or injuries, please include dates. _____

Please check if you have ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Are you pregnant and/or nursing? yes no

Review of Systems: Please check if you currently, or have you ever had any problems in the following areas:

Constitutional:	Respiratory	Allergic, immunology <input type="checkbox"/>
Weight loss/ gain <input type="checkbox"/>	Asthma <input type="checkbox"/>	Psychiatric <input type="checkbox"/>
Fever <input type="checkbox"/>	Chronic bronchitis <input type="checkbox"/>	Gastrointestinal
Lymphatic, hematologic	Emphysema <input type="checkbox"/>	Diarrhea <input type="checkbox"/>
Anemia/bleeding <input type="checkbox"/>	Vascular Cardiovascular	Constipation <input type="checkbox"/>
Ears, nose, mouth, throat	Diabetes <input type="checkbox"/>	Endocrine
Post nasal drip <input type="checkbox"/>	Stroke <input type="checkbox"/>	Thyroid <input type="checkbox"/>
Allergies/hay fever <input type="checkbox"/>	High blood pressure <input type="checkbox"/>	Other glands <input type="checkbox"/>
Sinus congestion <input type="checkbox"/>	Vascular disease <input type="checkbox"/>	Bones, joints, muscles
Runny nose <input type="checkbox"/>	Heart pain/disease <input type="checkbox"/>	Rheumatoid arthritis <input type="checkbox"/>
Chronic cough <input type="checkbox"/>	Integumentary	Muscle pain <input type="checkbox"/>
Dry throat/mouth <input type="checkbox"/>	Skin <input type="checkbox"/>	Joint pain <input type="checkbox"/>

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

Eye History: Have you ever had any of the following conditions?

Glaucoma <input type="checkbox"/> yes <input type="checkbox"/> no	Retina problem <input type="checkbox"/> yes <input type="checkbox"/> no	Crossed eyes <input type="checkbox"/> yes <input type="checkbox"/> no
Lazy eye <input type="checkbox"/> yes <input type="checkbox"/> no	Cornea problem <input type="checkbox"/> yes <input type="checkbox"/> no	Loss of vision <input type="checkbox"/> yes <input type="checkbox"/> no
Double vision <input type="checkbox"/> yes <input type="checkbox"/> no	Flashes/floaters <input type="checkbox"/> yes <input type="checkbox"/> no	Itching /burning <input type="checkbox"/> yes <input type="checkbox"/> no
Dry eyes <input type="checkbox"/> yes <input type="checkbox"/> no	Eye infections <input type="checkbox"/> yes <input type="checkbox"/> no	Blurred vision <input type="checkbox"/> yes <input type="checkbox"/> no
Redness <input type="checkbox"/> yes <input type="checkbox"/> no	Pain/soreness <input type="checkbox"/> yes <input type="checkbox"/> no	Halos <input type="checkbox"/> yes <input type="checkbox"/> no
Discharge <input type="checkbox"/> yes <input type="checkbox"/> no	Sties/chalazion <input type="checkbox"/> yes <input type="checkbox"/> no	other: _____

Do you wear glasses? yes no If yes, how old is your present pair of lenses? _____

Do you wear contacts? yes no If yes, what brand? _____ How often do you replace your lenses? _____

****Please turn this form over and complete side two****

Family History:

Please note any family history for the following conditions. M=mother, F=father, S=sibling, GP= grandparent

ÿ Blindness_____	ÿ Cataract_____	ÿ Crossed eyes_____
ÿ Glaucoma_____	ÿ Retinal disease_____	ÿ Macular degeneration_____
ÿ Arthritis_____	ÿ Cancer_____	ÿ Diabetes_____
ÿ Heart disease_____	ÿ High blood pressure_____	ÿ Kidney disease_____
ÿ Lupus_____	ÿ Thyroid disease_____	ÿ Other:_____

Social History:

Please list your hobbies or sports you participate in_____

Please list any occupational hazards_____

Do you drive? ÿyes ÿno If yes, do you have visual difficulty when driving? ÿyes ÿno If yes, please describe._____

Do you smoke? ÿyes ÿno Do you drink alcohol? ÿyes ÿno Do you use illegal drugs? ÿyes ÿno If yes, please provide information as to type, amount, how long._____

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. Our Notice of Privacy Practices will be updated whenever our privacy practices change. If you sign this authorization, you can revoke it at anytime. You may not retroactively retract consent of the release of protected health information. If you want to revoke your authorization, send a written notice telling us that your authorization is revoked to PO BOX 5292 Topeka, KS 66605, attention privacy officer. We can elect to decline service to you if you choose not to sign this consent form.

PATIENT AUTHORIZATIONS: I understand that the following authorizations are to be used by R. Kevin Lenahan, Optometrist and Associates, including but not limited to, all physicians and staff members associated therewith. This authorization becomes effective on the date of the first service rendered. Copies of this agreement will be as valid as the original. This signed authorization will remain valid until written notification is received by this office stating otherwise.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize R. Kevin Lenahan, OD, PA, and Associates, and The Spectacle Eye Wear Center including but not limited to, all physicians and staff members associated herewith, to release any information deemed appropriate concerning my state of health for treatment, payment purposes, and health care operations such as to insurance companies, optical, laboratory, diagnostic testing entity, pharmacy, physician, auditor, attorney or adjuster on my behalf.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby authorize directly to R. Kevin Lenahan, Optometrist and Associates and The Spectacle Eye Wear 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 also agree that if, at anytime, there is need for legal action to be brought against any insurance company or other guarantors, I will be responsible for instigating such action. 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.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that a copy of R. Kevin Lenahan Optometrist & Associates' Notice of Privacy Practices was made available to me.

AUTHORIZATION TO TREAT A MINOR: I hereby authorize Dr. R. Kevin Lenahan 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 (or parent of minor/guardian)

date