

PATIENT INFORMATION

General Information:

Last Name:	First Name:	Middle Initial:	Date:
Address:	City:	State:	Zip Code:
Social Security Number:	Date of Birth:	Age:	
Home Phone Number:	Marital Status:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	

Employment Information:

Patient's Employer:	Occupation:	Work Phone: ()
Employer's Street Address:	Town:	State: Zip Code:
Spouse/Parent's Name (If pt. is a minor)		Relationship:
Employer:	Occupation:	Work Phone: ()

EMERGENCY CONTACT:

Emergency Contact:

Last Name:	First Name:	Home Phone: ()
Relationship:		Work Phone: ()

Billing Information:

Person Responsible for this Account (if different from patient):		Home Phone:
Last Name:	First Name:	()
Social Security #:	Date of Birth:	
Employer:	Occupation:	Work Phone: ()
Employer's Street Address:	Town:	State: Zip Code:
Non-Custodial Parent (if applicable):		Home Phone:
Last Name:	First Name:	()

Insurance Information:

Primary Insurance Company Name:	Office Phone: ()
Address:	Town: State: Zip Code:
Policy Number:	Group Number:
Subscriber Name:	SS#: Date of Birth:
Employer:	Relationship to Patient:
Secondary Insurance Company Name:	
Office Phone: ()	
Address:	Town: State: Zip Code:
Policy Number:	Group Number:

MEDICAL RELEASE AUTHORIZATION

Insured party must sign for all claims. Dependent patient must also sign if not a minor. I authorize any insurance company, organization, employer, hospital, physician, dentist or pharmacist to release any information requested with regard to processing my claims. I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

INSURED PARTY SIGNATURE: X	DATE:
DEPENDENT PATIENT SIGNATURE IF NOT A MINOR: X	DATE:

PATIENT HISTORY RECORD

Patient Name: _____ DOB: _____ Today's Date _____

I was referred by: _____ Optometrist: _____

Family Physician: _____ Other Physicians: _____

Please answer the following questions about your medical status and history:

1. Please mark any medical conditions/diseases you currently have or have had:
 diabetes, high blood pressure, arthritis, bleeding problems, respiratory, heart disease, thyroid,
 cancer - list type _____ other: _____
2. Have you ever had a heart attack? Yes No If YES, when: _____
3. Have you ever had a stroke? Yes No If YES, when: _____
4. Mark any eye problems you have been diagnosed with: Cataracts, Glaucoma, Macular Degeneration,
 Retinal detachment, Wandering or "lazy" eye, other: _____
5. EYE SURGERIES: _____
6. OTHER SURGERIES: _____

ALLERGIES: No known allergies. YES If YES, list type of medicine/food & reaction.

Medication/Food

Reaction

Medication/Food	Reaction
_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS: List prescription & over-the-counter medications and dosage.

FAMILY AND SOCIAL HISTORY:

- List any medical or eye diseases which run in your family: Diabetes, Glaucoma, Cataracts, thyroid,
 Macular degeneration, Heart disease, High blood pressure, Respiratory, Arthritis.
 cancer - list type _____ other: _____
- Do you smoke? Yes No If YES, how much? _____
- Do you drink alcohol? Yes No If YES, how much? _____

EYE SURGERIES/Updates by Dr. Cohlmiä: (office use only) _____

WICHITA OPHTHALMOLOGY, P.A. NOTICE OF PRIVACY PRACTICES

Dear Patient,

Attached to this letter you will find our Notice of Privacy Practices. We are required by law to provide this notice to you and obtain your acknowledgement of its receipt prior to providing any services to you.

The following is a brief summary of the contents of the Notice. We encourage you to read the entire Notice and ask any questions you may have concerning its contents.

Your Rights Regarding Your Health Information. This section describes the following rights you have with respect to your health information and tells you how you may exercise these rights.

- Right to inspect and copy
- Right to request amendment
- Right to an accounting of disclosures
- Right to request restrictions on certain uses and disclosures
- Right to request alternative means of communication
- Right to receive a paper copy of our Notice of Privacy Practices

How To File Complaints Concerning Our Privacy Practices. This section tells you what you can do if you believe any of your rights have been violated. You will not be penalized for filing any complaint.

How We May Use and Disclose Health Information About You Without Your Specific Authorization. This section describes the different ways we may use or disclose your health information without first obtaining from you a specific authorization. These types of uses and disclosures are specifically permitted by federal law because it is assumed you would want us to use or disclose your information for these purposes, or because such use or disclosure is recognized as critical to the proper functioning of our health care system.

You will be asked to acknowledge your receipt of this Notice, and your acknowledgement will be maintained in your permanent record. You should keep this copy of the Notice. Another copy of this Notice will not be provided automatically at any later visit, but you may request a copy of the Notice at any time. Also, the Notice is posted at our facility and on our website for your review. If there is a material revision to the Notice at some later date, you again will be provided with a copy of the Notice and asked to sign an acknowledgement.

Maintaining the privacy of your health information is very important to us. Again, if you have any questions concerning the attached Notice, please do not hesitate to ask.

ACKNOWLEDGMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Wichita Ophthalmology, P.A.'s Notice of Privacy Practices with the effective date of April 14, 2003.

Signature of Patient/ Patient Representative

Date

Relationship

Original to be maintained in patient's permanent medical records.

Sam N. Cohlma, M.D. is an ophthalmologist specializing in treating medical and surgical conditions of the eye. Some of these conditions include but are not limited to glaucoma, cataracts, dry eyes, double vision, blurred vision, strabismus, esotropia, headaches, droopy eyelids, conjunctivitis, bumps or lesions on the eyes or eyelids, and others. You can expect an exam by Dr. Cohlma to be very thorough as he is concerned primarily with the overall health of your eyes.

If it is found during the course of the exam that there is a medical condition or a medical diagnosis is warranted, we will file the claim for services with your health insurance. If you have a condition that needs further treatment or if a procedure needs to be performed, we will obtain authorization for you from your insurance company prior to proceeding.

On rare occasions, Dr. Cohlma may refer you to an optometrist for a routine vision evaluation after he has examined your eyes. If your intention is to solely purchase optical hardware, you may be better served by an optometrist due to the fact that most optometrists' offices dispense glasses and contact lenses. **However**, for most patients, Dr. Cohlma can give prescriptions for glasses, which can in turn be filled at an optical dispensary of your choice. Such service, specifically refraction (92015), might or might not be covered by your insurance as a "non-covered service" or "not medically necessary." In such case, you understand that you will be responsible for the payment of \$80.00 for the refraction procedure.

We do accept almost all insurances, including vision riders and vision-only plans. This means that when you call your customer service number for your plan, we will show up as accepting your insurance. We just want you to be aware that we accept these insurances as a convenience for our patients, but routine vision exams are not the primary objective of our practice.

By your signature, you are acknowledging that you understand our determination process on how we file your insurance claims. If you have any questions, please feel free to ask our staff for any clarifications before signing this form.

Patient's Name

Patient's signature/Guarantor

Date