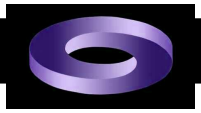
WELCOME  **Melissa Ramos Keusler, O.D.** Wichita, KS ◆ (316) 260-8788

Patient Name: _____
FIRST MIDDLE LAST

Street: _____

City: _____ State: _____ Zip: _____

Home phone: _____

Cell phone: _____ Work phone: _____

Email: _____

Social Security #: _____

Employer (or School): _____

Occupation (or Grade): _____

Birthdate: _____ Age: _____ Sex: M F

Preferred Method of Contact: ☐ Home phone ☐ Cell phone ☐ Work phone

Marital Status: ☐ Single ☐ Divorced ☐ Widowed

☐ Married: Spouse's Name: _____

If the patient is a minor, parents' names:

How did you first hear about our office?

☐ Friend or Relative: Who? _____
☐ Another Health Care Practitioner: Who? _____
☐ Insurance ☐ Walmart ☐ Sign
☐ Social Media ☐ Internet Search
☐ Other _____

PATIENT'S MEDICAL HISTORY

PLEASE CHECK ALL THAT APPLY.

EYES:	Loss of Vision	☐	Flashes of Light	☐
	Blurred Vision	☐	Floaters	☐
	Distorted Vision	☐	Dryness	☐
	Double Vision	☐	Redness	☐
	Cataract	☐	Mucous	☐
	Glaucoma	☐	Itching/Burning	☐

Do you wear glasses? ☐ Yes ☐ No

Do you wear contact lenses?

☐ Yes--*what brand?* _____ *solutions?* _____

☐ No--*are you interested in contacts lenses?* ☐ *Yes*

NEUROLOGICAL:	Headache	☐
	Migraines	☐
VASCULAR/	Diabetes	☐
CARDIOVASCULAR:	Stroke	☐
	High Blood Pressure	☐
LYMPHATIC/ HEMATOLOGIC:	Anemia	☐
RESPIRATORY:	Asthma	☐
	Chronic Bronchitis	☐
	Emphysema	☐
BONES/ JOINT/ MUSCLES:	Rheumatoid Arthritis	☐
	Muscle / Joint Pain	☐
IMMUNOLOGIC:	Lupus	☐
ENDOCRINE:	Thyroid/ Other Glands	☐
GENITOURINARY:	Kidney	☐
	Bladder	☐
EARS NOSE,	Allergies	☐
MOUTH, THROAT:	Hay Fever	☐
	Sinus Congestion	☐
	Chronic Cough	☐
	Dry Throat/ Mouth	☐
INTEGUMENTARY:	Skin Disorders	☐
PSYCHIATRIC:	Depression	☐
	Anxiety	☐
CONSTITUTIONAL:	Fever	☐
	Weight Loss/Gain	☐

Please List Any Major Injuries, Surgeries, or Hospitalizations

_____
_____
_____

Are You Currently Pregnant and/or Nursing? ☐Yes ☐No

CURRENT MEDICATIONS

Please list any medications you are currently taking
(Prescription or Over-the-Counter)

Name of Medication: Purpose of medication:

_____ ..... _____
_____ ..... _____
_____ ..... _____
_____ ..... _____
_____ ..... _____
_____ ..... _____
_____ ..... _____

List any medications you are allergic to:

_____
_____

Are you currently under the care of a physician? ☐ YES ☐ NO
Name of Physician: _____

PATIENT'S SOCIAL HISTORY

Do you use tobacco products? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Have you ever been exposed to or infected with:
☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

FAMILY MEDICAL HISTORY

(parents, grandparents, siblings, children, living or deceased)

	Relationship
☐ Cataracts	_____
☐ Glaucoma	_____
☐ Macular Degeneration	_____
☐ Retinal Detachment/ Disease:	_____
☐ Crossed Eyes	_____
☐ Diabetes	_____
☐ High Blood Pressure	_____

I have completed the above information to the best of my knowledge.

_____ _____
PATIENT/ GUARDIAN SIGNATURE DATE

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

PATIENT NAME **DOB:**

☐ Check here if Patient is the same as Person Financially Responsible

Name: _____
FIRST MIDDLE LAST

Street: _____

City: _____ State: _____ Zip: _____

Home phone: _____

Cell phone: _____

Work phone: _____

Email: _____

Social Security #: _____

Employer: _____

Birthdate: _____ Relationship to patient: _____

How will you settle your account today?
☐ Credit Card/ Debit Card ☐ Cash

If patient is a Minor, Parents' Names:

Father: Birthdate: _____

_____
FIRST MIDDLE LAST

Employer: _____

Mother: Birthdate: _____

_____
FIRST MIDDLE LAST

Employer: _____

If married: Spouse's Name: Birthdate: _____

_____
FIRST MIDDLE LAST

Employer: _____

Please complete the patient medical history on the other side ☞☞☞

I authorize my optometrist to discuss or release health information identifying me to the following individuals/entities:

_____ Processing & Settlement of Claim

_____ Minimal information required for further treatment/ Other: _____

1. This authorization is being made voluntarily and at my request.
2. In signing this authorization, I understand and acknowledge the following (*initial in the space provided*):

_____ I understand that this authorization is voluntary and that I may refuse to sign it.

_____ I understand that my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.

_____ I understand that I may revoke this authorization at any time by notifying my optometrist in writing of my intent to revoke this authorization, except to the extent that action has been taken in reliance on this authorization.

_____ I understand that once the disclosures authorized herein have been made, the information disclosed may be subject to re-disclosure by any recipient and no longer protected by federal privacy law.

_____ *I acknowledge that I received a copy of Dr. Melissa R. Keusler, OD, Notice of Privacy Practices.*

I do hereby swear that I have read and understand the above information.

Signature of Patient / Legal Representative _____ Date: _____

_____ I hereby authorize the release of any medical and/ or other information necessary to process this claim. I also authorize my insurance benefits to be paid directly to Dr. Melissa R. Keusler and understand that I will be financially responsible for services and materials not paid in full by my Medicare/ Medigap/ Insurance.

Non-Covered Services Statement

_____ I have selected to receive services that are not covered by my Medicare/ Medigap/ Insurance or that are not medically necessary. I agree to pay those charges at the time they are provided. I further agree to reimburse either my Medicare/ Medigap/ Insurance or Dr. Melissa Keusler for any incorrect payments made by my Medicare/ Medigap/ Insurance on my behalf.

_____ *NO INSURANCE: I am responsible for my charges.*

Signature of Patient / Legal Representative _____ Date: _____