Date_____ Date of Birth_____ **Kimberly Eye Clinic**

First Name_____ M.I_____ Last Name_____

Address_____ City_____ State_____ Zip_____

Phone_____ E-mail_____

Please **initial** after you have signed, read and understood each statement

_____ I authorize the release of any medical records or other information necessary to process my claims. I understand that I am financially responsible for charges, regardless of insurance benefits.

_____ I acknowledge that I was offered or received a copy of Kimberly Eye Clinic's "Notice of Privacy Practices." (HIPAA Compliance)

HIPAA Consent Form

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations.

You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Kimberly Eye Clinic may condition treatment upon the execution of this consent. By signing this form, you acknowledge that by presenting yourself as a patient or child you consent for vision and medical eye care by the doctors and staff of Kimberly Eye Clinic. You hereby grant full authority to the optometrists and their respective assistants to administer and perform any and all drugs, treatments, test, or diagnostic procedures to or upon me, which may be advised or necessary.

Additionally, I give permission to the following person(s) listed to receive all my health care and medical service information

Name_____Relationship_____

Name_____Relationship_____

Eye Health – Circle all that apply to YOU

Glaucoma	Cataract	Macular Degeneration	Surgery	Patching	Retinal Detachment
Blurred Vision	Injury	Dry eye	Other_____		None

How often do you drink alcohol Never Sometime Frequently

Do you currently smoke Yes No If yes How Much? _____

Did you previously smoke? Yes No When did you Quit? _____

Hobbies

Allergies – List all allergies, including medication and environment

Medications – List both prescription and over-the-counter medications

Height_____ Weight_____ (Required for electronic health records)

Family History – Mark if any apply **M-Mother F-Father B-Brother S-Sister D-Daughter S-Son**

CATARACT M F B S D SON	**BLINDNESS** M F B S D SON	**DIABETES –** *INSULIN* M F B S D SON	**LOW BLOOD PRESSURE** M F B S D SON
MACULAR DEGENERATION M F B S D SON	**LAZY EYE** M F B S D SON	**DIABETES-** *NON INSULIN* M F B S D SON	**HYPERTHYROID (HIGH)** M F B S D SON
GLAUCOMA M F B S D SON	**CANCER** M F B S D SON	**HIGH BLOOD PRESSURE** M F B S D SON	**Hypothyroid (LOW)** M F B S D SON

Please provide us with YOUR health information by marking all of the conditions that currently apply:

Constitutional

_____Developmental Disability
_____Cancer
_____Fatigue Syndrome
_____Other

Ear, Nose, Mouth & Throat

_____Hearing loss
_____Sinusitis
_____Dry Mouth
_____Laryngitis
_____Other

Neuro

_____Multiple Sclerosis
_____Epilepsy
_____Cerebral Palsy
_____Tumor
_____Stroke/CVA
_____Migraine
_____Autism Disorder
_____Other

Psychiatric

_____Depression
_____Attention Deficit/ADHD
_____Anxiety Disorder
_____Bipolar Disorder
_____Other

Hematologic/Lymphatic

_____Anemia
_____Large Blood Loss
_____Ulcer
_____High Cholesterol
_____Other

Cardiovascular

_____ Hypertension
_____ Stroke/CVA
_____ Heart Disease
_____ Vascular Disease
_____ Congestive Heart Failure
_____ Other

Respiratory

_____Smoker
_____Asthma
_____Bronchitis
_____Emphysema
_____Chronic Obstruction (COPD)
_____Sleep Apnea
_____Other

Gastrointestinal/G.I.

_____Crohn's
_____Colitis
_____Ulcer
_____Acid Reflux
_____Celiac Disease
_____Other

Genitourinary

_____Kidney Disease
_____Prostate Disease/Cancer
_____Pregnant/Weeks_____
_____Nursing
_____STD Herpetic/Chlamydia
_____ Other

Musculoskeletal

_____Osteoarthritis
_____Arthritis
_____Fibromyalgia
_____Muscular Dystrophy
_____Ankylosing Spondylitis
_____Osteoporosis
_____Gout
_____Other

Integumentary

_____Eczema
_____Rosacea
_____Psoriasis
_____ Herpes Simplex/Cold Sores
_____Herpes Zoster/Shingles
_____Other

Endocrine

_____Type 2 Diabetes Mellitus
_____Type 1 Diabetes Mellitus
_____Thyroid Dysfunction
_____ Hormonal Dysfunction
_____Other

Allergic/Immune

_____Drug Allergies
_____Environmental Allergies
_____Rheumatoid Arthritis
_____Lupus
_____Sjogren's Syndrome
_____Other

_____ _____

Patient/Guardian Signature **Date**