Southern KY Eye Center, PSC
Office of Mark A. Henry, M.D.

Patient Name: _____ today's date: _____

Review of Systems

Eyes *

Previous Surgery	☐ YES	☐ NO
Contact Lens	☐ YES	☐ NO
Pain	☐ YES	☐ NO
Double Vision	☐ YES	☐ NO
Glaucoma	☐ YES	☐ NO
Cataracts	☐ YES	☐ NO
Macular Degeneration	☐ YES	☐ NO
Dry Eyes	☐ YES	☐ NO
Flashes	☐ YES	☐ NO
Floaters	☐ YES	☐ NO

Respiratory *

Cough	☐ YES	☐ NO
Congestion	☐ YES	☐ NO
Wheezing	☐ YES	☐ NO
Asthma	☐ YES	☐ NO

Blood/Lymphnodes *

Easy Bruising	☐ YES	☐ NO
Gums Bleed Easily	☐ YES	☐ NO
Prolonged Bleeding	☐ YES	☐ NO
Heavy Asprin Use	☐ YES	☐ NO

Gastrointestinal *

Heartburn	☐ YES	☐ NO
Nausea/Vomiting	☐ YES	☐ NO
Jaundice/Hepatitis	☐ YES	☐ NO

MusculoSkeletal *

Stiffness	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO
Joint Pain/Swelling	☐ YES	☐ NO

Ear, Nose, and Throat *

Hard of Hearing	☐ YES	☐ NO
Ringing In Ears	☐ YES	☐ NO
Vertigo	☐ YES	☐ NO

Genito-Urinary *

Pain/Difficulty	☐ YES	☐ NO
Blood in Urine	☐ YES	☐ NO
History of Kidney Stones	☐ YES	☐ NO
History of STD's	☐ YES	☐ NO

Skin *

Rash/Sores	☐ YES	☐ NO
Lesions	☐ YES	☐ NO
Hives/Eczema	☐ YES	☐ NO

Cardiovascular *

Chest Pain	☐ YES	☐ NO
Dizziness	☐ YES	☐ NO
Fainting Spells	☐ YES	☐ NO
Shortness of Breath	☐ YES	☐ NO
Irregular Heart Beat	☐ YES	☐ NO
Difficulty Lying Flat	☐ YES	☐ NO

Psychiatric *

Anxiety/Depression	☐ YES	☐ NO
Mood Swings	☐ YES	☐ NO
Difficulty Sleeping	☐ YES	☐ NO

Neurological *

Seizures	☐ YES	☐ NO
Weakness/Paralysis	☐ YES	☐ NO
Numbness	☐ YES	☐ NO
Tremors	☐ YES	☐ NO

Endocrine *

Increased Thirst	☐ YES	☐ NO
Increased Hunger	☐ YES	☐ NO
Increased Urination	☐ YES	☐ NO
Increased Sweating	☐ YES	☐ NO
Fingernail Changes	☐ YES	☐ NO

Immunologic *

Hives	☐ YES	☐ NO
Itching	☐ YES	☐ NO
Runny Nose	☐ YES	☐ NO
Sinus Pressure	☐ YES	☐ NO

Constitutional *

Fatigue/Weakness	☐ YES	☐ NO
Fever	☐ YES	☐ NO
Weight Gain/Loss	☐ YES	☐ NO

Family History *

☐ Diabetes	☐ Stroke	☐ Blindness	☐ Macular Degeneration	☐ Arthritis
☐ Cancer	☐ TB	☐ Cataracts	☐ Retinal Disease	☐ Lazy Eye
☐ Heart Disease	☐ Kidney Disease	☐ Glaucoma	☐ High Blood Pressure	Other/Explanation _____

Social History *

Smoking Status _____

Alcohol ☐ YES ☐ NO If Yes: How Much? _____

Drugs ☐ YES ☐ NO Drugs Used _____

Do you wear glasses? Yes or No
IF so how old is your current prescription: _____

Do you wear contact lenses?; Yes or NO
IF yes what is the brand and strength: _____

Name: _____ Date: _____

Presenting problem (brief explanation for the reason for today's visit):
Are there any activities that worsen the problem? (Reading, driving, light etc.):
Are there any problems associated with the problem? (glare, light sens etc)

How long have you had this problem:	Which eye is affected?
Is the problem constant, occasionally, or just once?	Please rate the severity of the problem (circle) Mild, minimal, significant, moderate or severe

Allergies:
Primary Care Physician:

Past Eye Problems:	Past eye surgeries & dates if known:	Current Eye Medications:

Past Medical History:	Past Medical Surgeries:	Current Medications:

→→→→→→→→PLEASE FLIP OVER TO THE OTHER SIDE AND CONTINUE →→→→→→→→

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

CONSENT TO WIRELESS TELEPHONE CALLS: If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including, but not restricted to communications regarding billing and payment for items and services, unless I notify, Dr. Henry's office to the contrary in writing. In this section, calls and text messages include, but is not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the office, affiliates, contractors, servicers, clinical providers, attorneys, or its agents including collection agencies.

Patient Name (Please Print):_____

Patient Signature:_____ **Date:**_____

CONSENT TO EMAIL USAGE: If at any time I provide an email address at which I may be contacted, unless I notify Dr. Henry's office to the contrary in writing, I consent to receiving portal instructions, statements, bills, marketing material for new services, and payment receipts at that email address from the office of Dr. Henry.

Patient Name (Please Print):_____

Patient Signature:_____ **Date:**_____

Today's Date:_____

Patient Name:_____

Date of Birth:_____SS#:_____

Address:_____

City:_____State:_____Zip:_____

Phone #:_____

Cell #:_____

Email address:_____

This will be mandatory for you to view your records in the web based patient portal www.myeyecarerecords.com.

Sex: Male or Female Age:_____

Race:_____ Marital Status:_____

Spouse's Name:_____

Date of Birth:_____SS#:_____

Parent/Guardian/POA:_____

Relation:_____ Phone #:_____

Patient Employer:_____

Work #:_____

Emergency Contact:_____

Phone:_____ Relation:_____

Who is responsible for this account?:_____

Address:_____

Phone:_____

Is this visit today the result of an injury? If so, please see the receptionist. Additional paperwork may be required.

Were you referred by another doctor?_____

If so, whom?_____

If not, who may we thank for referring you? (friend, website, radio, etc.)

_____

_____

PLEASE NOTE THAT COPAYS, DEDUCTIBLES AND PAST DUE BALANCES ARE TO BE PAID AT TIME OF VISIT.

I certify that I have insurance coverage through:

_____
(name of insurance carrier)

And assign directly to Dr. Mark Henry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I authorize the use of my signature on all insurance submissions and any insurance related matters.

Dr. Henry may use my healthcare information and may disclose such information to my insurance companies, their agents, and their internet based portals for the purpose of obtaining payment for services and determining insurance benefits, co-pays, deductibles, and co insurance amounts or the benefits payable related services.

_____
Signature

We care about your privacy. The information we collect about you is protected by the Federal Health Insurance Portability and Accountability Act (HIPAA) and the HITECH act of 2009. We are required to give you notice of our privacy practices. Only people who have both the need and the legal right may see your information. Unless you give us permission in writing, we will only discuss your information for purposes of treatment, payment, business operations, and/or when we are required by law to do so.

In the event of my absence or by my consent I give the following individuals authorization to my medical records to be either discussed in person or via phone. I realize personal information may be disclosed to these individuals. By signing this consent I by no means will hold Dr. Mark Henry or his staff liable for disclosing such information to them. Dr. Henry and his staff will not be able to discuss any information with anyone who is not on this list (except insurance companies, other doctors, pharmacies and anyone deemed necessary).

List of people you give us permission to speak with:

_____

_____

_____ _____
Patient Signature Date