



# Harkins Eye Clinic

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Phone 308-384-9148, Fax 308-384-9158

Date: \_\_\_\_\_

www.harkinseyeclinic.com

Name (prefix & suffix): \_\_\_\_\_

Sex:    M    F    Responsible Party (Self, Parent, or POA): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

Ethnicity: \_\_\_\_\_Hispanic or Latino \_\_\_\_\_Non-Hispanic or Latino \_\_\_\_\_Unknown \_\_\_\_\_Declined to Specify

Race: \_\_\_\_\_ American Indian or Alaska Native \_\_\_\_\_Asian \_\_\_\_\_Black or African American \_\_\_\_\_White  
\_\_\_\_\_ Native Hawaiian or Other Pacific Islander \_\_\_\_\_Other Race \_\_\_\_\_Declined to Specify

Preferred Language: \_\_\_\_\_Preferred Phone # \_\_\_\_\_Cell # \_\_\_\_\_

Voice reminder to this number(home) Yes/No    Text reminder to this number(cell): Yes/No

Email: \_\_\_\_\_ Work # \_\_\_\_\_

Marital Status (circle):    Single    Married    Separated    Widowed    Divorced

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse: \_\_\_\_\_ Spouses Occupation: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Name of Primary Insurance: \_\_\_\_\_Name of Secondary Insurance: \_\_\_\_\_

Insured's Name, Date of Birth, & SSN: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Were you referred by someone, if YES, by who? : \_\_\_\_\_

If under the age of 18, parents name and phone: \_\_\_\_\_

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this form and have completed all the blanks. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Signature \_\_\_\_\_Date \_\_\_\_\_

Parent (if minor) \_\_\_\_\_Date \_\_\_\_\_

*CONTINUED ON BACK*

## NOTICE OF PRIVACY PRACTICES RECEIPT

I have been made available copy of the Notice of Privacy Practices for Harkins Eye Clinic containing a complete description of the uses and disclosures of my health information. I understand that Harkins Eye Clinic has the right to change its Notice of Privacy Practices if necessary and that I may contact this office at any time to obtain a current copy of the Notice.

**Patient Signature:** \_\_\_\_\_

**Representative Signature:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Date Signed:** \_\_\_\_\_

## COMMUNICATION RELEASE FORM

I hereby give **permission to communicate** with the following individuals regarding my examination, treatment, and statement of account at Harkins Eye Clinic.

Please list **names and phone numbers** of all that apply to communicate with:

☐ Spouse \_\_\_\_\_

☐ Children \_\_\_\_\_

☐ Son-in-law and daughter-in-law \_\_\_\_\_

☐ Grandchildren \_\_\_\_\_

☐ Parents \_\_\_\_\_

☐ Brothers and sisters \_\_\_\_\_

☐ Nieces and Nephews \_\_\_\_\_

☐ Friends - please print names and phone numbers below

\_\_\_\_\_  
\_\_\_\_\_

☐ Other - please print names and phone numbers below

\_\_\_\_\_  
\_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Personal Representative (if applicable) \_\_\_\_\_

# HARKINS EYE CLINIC

Name \_\_\_\_\_

Have you ever been diagnosed with the following medical conditions and/or currently being treated for: Please circle all that apply:

Cataracts	Anxiety	Methicillin Resistant Staph Aureus (MRSA)
Macular Degeneration	Depression	HIV/AIDS
Glaucoma	Asthma	Hepatitis A, B, or C
Lazy Eye	Sleep Apnea	Osteoporosis
Dry Eye	Emphysema	Obesity
Droopy Eyelids	Tuberculosis	Diverticulitis
Eyelid Inflammation	Dementia	Acid Reflux (GERD)
Heart Disease	Stroke	Hearing Loss
Coronary Artery Disease	Diabetes	
Atrial Fibrillation	Migraine w/w/o visual disturbance	
COPD	Kidney Disease	
Heart Attack	Thyroid Disease	
Hypertension	Cancer	
High cholesterol	Arthritis (Rheumatoid or degenerative)	

**Review of Systems:** Do you **CURRENTLY** have any of the following, please circle all that apply:

## **Cardiovascular**

Chest Pain  
Irregular Heartbeat  
Shortness of Breath

## **HEENT**

Dizziness  
Hearing Loss  
Hoarseness  
Ringing in Ears  
Sore Throat  
Nose

## **Musculoskeletal**

Back pain  
Joint pain  
Muscle aches  
Stiffness  
Swelling

## **Respiratory**

Cough  
Trouble breathing  
Wheezing

## **Blood Pressure Control**

Good BP control  
Borderline BP control  
Poor BP control  
Unknown BP control

## **Constitutional**

Fatigue  
Fever  
Night Sweats  
Weakness

Weight Loss

## **Hematologic**

Bleeding  
Bruising  
Tender Nodes

## **Neurological**

Balance Problems  
Headache  
Numbness  
Tingling

## **Skin**

Hair loss  
Rash  
Skin Lesions

## **Diabetes Control**

Good DM control  
Borderline DM control  
Poor DM control  
Unknown DM control

## **Genitourinary**

Genital discharge  
Genital lesions  
Painful Urination  
Urgency

## **Metabolic**

Cold intolerance  
Excess hunger  
Excessive thirst  
Frequent urination  
Heat intolerance

## **Psychiatric**

Anxiety  
Depression  
Insomnia  
Irritability  
Nervousness

## **Allergy**

Itching  
Hives  
Chronic Runny

Seasonal Allergies

## **Are you pregnant**

No  
Yes(how many wks)

## **Gastrointestinal**

Diarrhea  
Vomiting  
Heartburn  
Abdominal pain

**PAST SURGICAL / LASER PROCEDURES (EYE)**

**PLEASE CHECK ALL THAT APPLY WITH APPROXIMATE DATE OF PROCEDURE & BY WHOM.**

Cataract Surgery \_\_\_\_\_ Laser (type) \_\_\_\_\_

Glaucoma Surgery \_\_\_\_\_ Muscle surgery \_\_\_\_\_

Retinal Detachment \_\_\_\_\_ Retinal Tear \_\_\_\_\_

LASIK / PRK \_\_\_\_\_ RK \_\_\_\_\_

Eye Injections (# of injections & dates) \_\_\_\_\_

**PAST SURGICAL PROCEDURES (NON-EYE related)** Please list any major surgeries (joint replacement, heart, etc.) you may have had with approximate date.

\_\_\_\_\_  
\_\_\_\_\_.

**FAMILY HISTORY:** Please Circle any of the conditions that may apply in your family.

**Glaucoma      Diabetes      Heart Dz.      Stroke      Corneal Dz.      Thyroid Dz.**

**Macular Degeneration      Retinal Tear / Detachment      Cataracts      Lazy Eye**

**ALLERGIES: (With reaction, if known)** \_\_\_\_\_

\_\_\_\_\_.

**Please give a current list of medications with dosing and milligrams to the front office to copy or please list.**

\_\_\_\_\_  
\_\_\_\_\_.

**SOCIAL HISTORY (PLEASE CIRCLE ALL THAT APPLY)**

**Smoke      Alcohol      Recreational Drugs      None**

**Do you wear contact lenses? If so what type, brand, power, and base curve (BC).  
Please list.**

\_\_\_\_\_

**I have read all the information on this form and have completed all the blanks. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.**

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PARENT (if minor)** \_\_\_\_\_ **DATE** \_\_\_\_\_