Dr. David Kingrey / Dr. Jeffrey Boomer / Dr. Annah Fowler / Dr. Brandon Kingrey
Vision Surgery Consultants / Waterfront Surgery Center
Phone: (316) 263-6273

East Wichita	Downtown	Newton
1530 N Lindberg Cir	1100 N Topeka	218 S Kansas Ave
Wichita KS 67206	Wichita KS 67214	Newton KS 67114

PATIENT LEGAL NAME: _____

BIRTH DATE (MM/DD/YYYY): ____ ____ / ____ ____ / ____ ____ ____ ____

Would you like to receive appointment reminders and other communication from our office by?

❒ **Text Message** **Number:** _____

❒ **Email:** _____

❒ **None** **Patient Initials** _____ **Date** _____

IF YOU ARE NOT AVAILABLE - WHO MAY WE COMMUNICATE WITH?

Name:	Relationship:	Phone:	Text
_____	_____	_____	❒
_____	_____	_____	❒
_____	_____	_____	❒

Communicate with self **ONLY** ____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices from Vision Surgery Consultants.

X_____ _____
Signature Date

If signing this as a personal representative of the patient, describe the relationship to the patient.

_____ _____
Signature Relationship to patient

_____
Date

For office use only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign

__ Communications barriers prohibited

__ An emergency situation prevented us from obtaining acknowledgement

Date _____

Legal Name _____
First M. Init. Last

Preferred Name _____

Address _____

_____
City State Zip

Primary Phone _____ ☐ Home ☐ Cell ☐ Other
please include area code

Secondary Phone _____ ☐ Home ☐ Cell ☐ Other
please include area code

E-mail: _____

Sex: M ___ F ___ Age _____ Birth date _____

Have you ever visited our office under another name?
(divorce, marriage, adoption, etc.) ☐ Yes ☐ No

If yes, what name? _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Patient SS# _____

Patient's Occupation _____

Employer _____

Employer Address _____

Work Phone # _____

INSURANCE

Primary Insurance _____

Secondary Insurance _____
if different than patient

Subscriber Name: _____
if different than patient

Relationship to patient: _____

Birth date: _____ SS# _____

Currently a resident in skilled nursing home? ☐ Yes ☐ No

Name of nursing home: _____

_____

Referred by: ☐ Doctor ☐ Friend ☐ Internet ☐ Relative ☐ Other

Referral Name: _____

AUTHORIZATION OF TREATMENT: I authorize my physicians Dr. David Kingrey, Dr. Jeffrey Boomer, Dr. Annah Fowler, and/or Dr. Brandon Kingrey to examine, diagnose and treat any eye related illness I may have.

AUTHORIZATION TO RELEASE INFORMATION: I authorize Dr. David Kingrey, Dr. Jeffrey Boomer, Dr. Annah Fowler, and/or Dr. Brandon Kingrey to disclose information regarding my illness to my Physician, Optometrist, Medical Facility, or my Insurance Company. A photostat copy of this authorization will be considered valid.

CONTACT RELEASE INFORMATION: I authorize/permit Vision Surgery Consultants ie: Dr. David Kingrey, Dr. Jeffrey Boomer, Dr. Annah Fowler, and/or Dr. Brandon Kingrey and their business associates to contact me, and all other responsible parties on my account, on our cell phone or other mobile devices concerning any and all aspects of my account.

ASSIGNMENT OF BENEFITS: I assign and authorize for direct payment of medical benefits otherwise payable to me by my insurance to: Vision Surgery Consultants, P.A. I understand that I am financially responsible for charges not covered by my insurance. If incorrect or wrong insurance is supplied to this office, or if I have AN HMO INSURANCE AND DO NOT HAVE PRIOR APPROVAL IN WRITING BY MY PRIMARY CARE PHYSICIAN TO BE SEEN, then I agree to pay for all charges if examined.

CANCELLATION POLICY: If you do not cancel or reschedule your appointment within 24 business hours notice, we may assess a $75.00 No-Show service charge. This charge is not reimbursable by your insurance company. You will be billed directly. After three no-shows to your appointment, our practice may decide to terminate its relationship with you.

EMERGENCY CALL POLICY: Our emergency line is intended for true medical emergencies only. If you call the emergency line after regular business hours for a non-emergency matter, a **$75 after-hours call fee** could apply. This fee is **not covered by insurance** and will be billed directly to you.

Signature: X _____ Date _____

Patient Name:_____DOB:_____Date:_____

Vision Preference Questionnaire

When you have a lens implant, it is important to consider your individual vision and lifestyle preferences. Although it has not yet been determined if you are a candidate for any procedure, this questionnaire will help us make recommendations during your exams.

Please mark an "X" on the following scale to describe your personality.

I am easy-going															I am a perfectionist

Occupations / Hobbies: _____

1. Would you like to have vision far away and up close WITHOUT glasses? ___Yes ___No

2. Would you be willing to pay out of pocket to minimize the need for glasses?
   ____Yes ____No ____Maybe

3. Please tell us how you use your eyes on a daily basis so we can personalize your vision care.

Near (12-20 in)	Intermediate (15-24 in)	Distance (6-20 ft)
Reading/Cell Phone	Shaving	Watching TV/Movies
Applying Makeup	Computer Use	Driving
Sewing/Threading Needles	Cards/Table games	Shopping
Crossword Puzzles	Cooking	Golf/Outdoor Activities
Other:_____	Other:_____	Other:_____

4. If, after cataract surgery, you could see far and near without glasses but you may see halos around headlights for several months, would you find this acceptable? ___Yes ___ No

5. Please mark an "X" on the following scale to describe your preferences.

I want/prefer to wear glasses							I don't mind wearing glasses							I DO NOT want to wear glasses

Please sign below and return this form to the receptionist before your exam.

Patient Signature: _____

PATIENT'S NAME _____ HEIGHT _____ WEIGHT _____ SEX ___ AGE____

Pharmacy: _____

Address: _____ Phone: _____

Primary Care Doctor's Name: _____ Date last seen _____

Address: _____

DURABLE POWER OF ATTORNEY ❒ **YES** ❒ **NO** **(If yes, please provide a copy.)**

ADVANCED DIRECTIVE (Living Will) ❒ **YES** ❒ **NO** (If yes, you may provide a copy.)

EYE HEALTH HISTORY

Optometrist's Name _____ Date of last eye exam_____

Address: _____

Do you wear glasses? ❒ Yes ❒ No ❒ All the time ❒ Reading ❒ Driving

What is the age of your current pair of glasses? _____

Do you wear contacts? ❒ Yes ❒ No ❒ Hard ❒ Soft ❒ Astigmatism ❒ Hrs/Days _____

HISTORY OF DISEASE

Are you being treated for or have you had any of the following?: **PLEASE CIRCLE Y or N**

LUNG

Emphysema / COPD/ Asthma.....Y N
Chronic or A.M. Cough.....Y N
Recent "Cold".....Y N
Shortness of Breath .....Y N
Sleep apnea / CPAP .....Y N
Blood clots / Pulmonary Embolism ....Y N
Wearing Oxygen .....Y N
How Much _____

VASCULAR

High Blood Pressure .....Y N
Heart Disease/Heart Attack.....Y N
Year _____

Chest Pain/Angina .....Y N
Last Experienced_____

Coronary Stent .....Y N
When _____

Congestive Heart Failure .....Y N
Palpitations/Irreg/A-Fib.....Y N
Pacemaker / AICD .....Y N
Stroke / TIA .....Y N

Bleeding Disorder / Sickle Cell.....Y N
High Cholesterol.....Y N

SYSTEMIC

Diabetes .....Y N
Insulin / NonInsulin / Diet
Type 1 or Type 2 _____

Thyroid Condition .....Y N
Jaundice.....Y N
Kidney / Bladder .....Y N
Dialysis .....Y N
Reflux / Bowel Disease .....Y N
Hepatitis B, C .....Y N
HIV Positive.....Y N
Fainting / Dizziness .....Y N
Tremors / Parkinson's .....Y N
Seizures / Epilepsy.....Y N
Neuromuscular Disease.....Y N
Restless Leg Syndrome .....Y N
Cancer.....Y N
Date & Type_____
_____
_____

Autoimmune Disease .....Y N
Type_____

Dementia / Alzheimer's .....Y N
Arthritis .....Y N
Back / Neck Problems.....Y N
Are you pregnant now?.....Y N
Depression / Anxiety .....Y N
Blood thinner.....Y N
Shingles .....Y N
When _____
Where_____

Hard of Hearing/Hearing Aid .....Y N
Physical Limitations.....Y N
Explain _____

Had MRSA? .....Y N
When _____
Where_____

Please list other serious medical conditions
_____
_____

Have you ever taken medication for an enlarged prostate? ❒ Y ❒ N Medication name?_____

SOCIAL HISTORY: Tobacco use / smoking ❒ Y ❒ N How much?_____ Have you quit? ❒ Y ❒ N How long ago? _____
Alcohol use ❒ Y ❒ N Amt per day or week_____ Illegal drug use? ❒ Y ❒ N

FAMILY HISTORY:

Has any member of your family had these diseases? ❒ Blindness ❒ Cataract ❒ Glaucoma ❒ Diabetes ❒ Hypertension
❒ Heart Disease ❒ Stroke ❒ Cancer ❒ Thyroid Disease ❒ Arthritis. ❒ Other heritable disease _____

SURGICAL HISTORY:

Previous Eye Surgery ❒ Y ❒ N Please List _____
Other Surgeries ❒ Y ❒ N Please List _____

Please turn over and complete both sides. 

ALLERGIC TO ANY MEDICATIONS? ❒ **Y** ❒ **N** If yes, list medication and reaction below.

Allergies:	Reaction:	Allergies:	Reaction:

ARE YOU ALLERGIC TO LATEX? ❒ **Y** ❒ **N** If yes, describe reaction _____

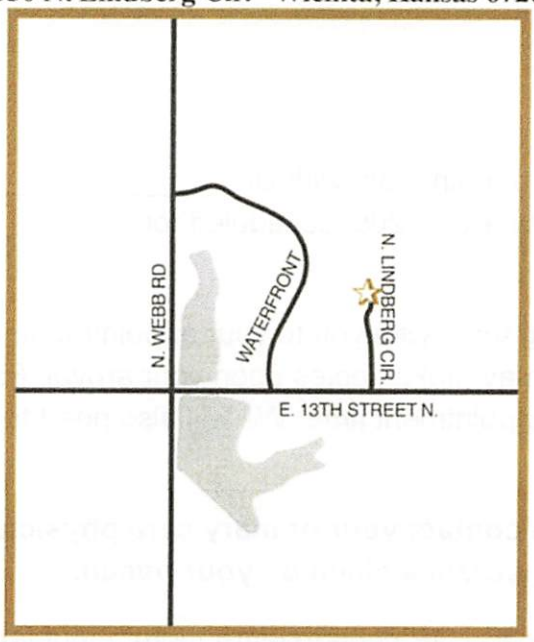
PLEASE LIST ALL MEDICATIONS

❒ **I am in good general health and take NO medications.**

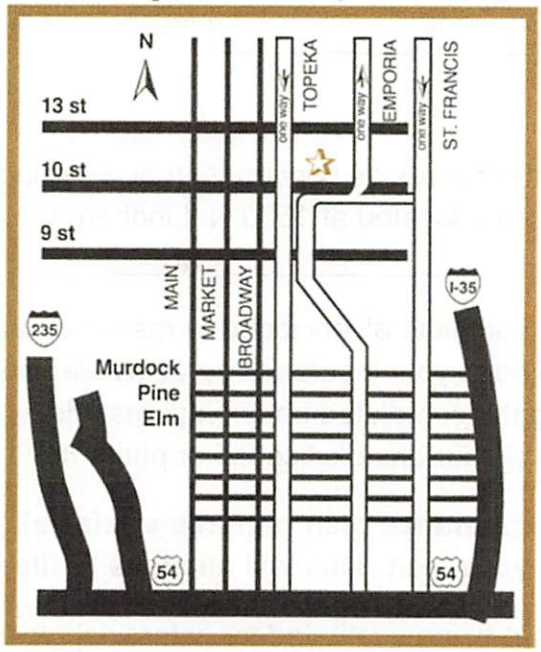
Prescriptions, Over-the-Counter, and ALL eye drops.

Medication	Dosage	How Often	How Taken (oral, drops, injections, etc.)

EAST WICHITA
1530 N. Lindberg Cir. - Wichita, Kansas 67206



DOWNTOWN WICHITA
1100 N. Topeka - Wichita, Kansas 67214



NEWTON
218 S. Kansas Ave. - Newton, Kansas 67114