KATHRYN M. GARDNER, M.D.

EXISTING PATIENT INFORMATION AND UPDATE

Please help us update your records and medical history! We have found that most of our patients have new personal data to report. Particularly important are your contact telephone numbers and email address, as this information will help us provide appointment confirmations. We also need updated Office and Privacy Practice Policy signatures. Many thanks!

NAME: _____ TODAY'S DATE_____

DOB_____AGE_____ MALE____FEMALE___ SOCIAL SECURITY #_____

HOW DO YOU WISH TO BE ADDRESSED (TITLE, NICKNAME):_____

HOME ADDRESS_____

CITY: _____STATE_____ZIP_____

HOME PHONE _____ CELL PHONE_____

WORK PHONE_____ EMAIL ADDRESS_____

VOICEMAIL WHERE WE MAY SAFELY LEAVE MEDICAL MESSAGES REGARDING APPOINTMENTS AND TEST/LAB RESULTS:_____

OCCUPATION_____EMPLOYER'S ADDRESS_____

CITY:_____STATE_____PHONE_____

MINOR ___SINGLE___MARRIED___LONGTERM PARTNER___WIDOWED___DIVORCED_____

SPOUSE/PARTNER NAME_____PHONE_____

EMERGENCY CONTACT NAME_____ PHONE_____

IF UNDER 18 OR A STUDENT: NAME OF PARENT/GUARDIAN:_____

PARENT'S ADDRESS:_____PHONE_____

REFERRED BY:_____PRIMARY PHYSICIAN:_____

PHYSICIAN'S ADDRESS:_____PHONE_____

EXISTING PATIENT MEDICAL AND EYE HISTORY

Patient Name_____DOB_____Date_____

Medications andSupplements_____

_____

Eye Medications_____

Medication Allergies_____

Updated Family History Diabetes _____ Hypertension _____ Glaucoma_____Macular Degeneration___Retinal Detachment ____Strabismus (crossed eyes)/lazy eye_____ Blindness____

Updated Medical History_____

Updated Eye History _____

_____

Current Eye Symptoms and Concerns_____

_____

_____

PLEASE NOTE THAT WE ARE NOT PROVIDERS FOR ANY INSURANCE COMPANY OR FOR MEDICARE (WE HAVE "OPT-OUT" STATUS).

PRIMARY INSURANCE:_____BILLING ADDRESS:_____

INS. ID # _____GROUP #_____SUBSCRIBER NAME:_____

CONSENT FOR MEDICAL DIAGNOSIS AND TREATMENT

I HEREBY AUTHORIZE KATHRYN M. GARDNER, M.D. TO PERFORM THOSE MEDICAL, SURGICAL AND DIAGNOSTIC SERVICES WHICH ARE DEEMED NECESSARY FOR MY HEALTH CARE.

SIGNATURE_____DATE_____

PATIENT RESPONSIBILITY FOR PAYMENT

I HAVE READ AND UNDERSTAND THE FINANCIAL AND INSURANCE POLICY ESTABLISHED BY THE PRACTICE OF KATHRYN M. GARDNER, M.D., AND RECOGNIZE THAT SHE IS NOT A PARTICIPANT IN ANY INSURANCE PLAN OR IN THE MEDICARE PROGRAM ("OPT-OUT STATUS").

SIGNATURE_____DATE_____

CANCELLATION POLICY

I HAVE READ AND UNDERSTAND THE CANCELLATION POLICY AND $200.00 CANCELLATION FEE ASSESSED FOR LATE CANCELLATIONS (LESS THAN 24 HOURS) AND NO-SHOWS FOR COMPREHENSIVE EYE EXAMINATION APPOINTMENTS.

SIGNATURE_____DATE_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE RECEIVED (OR DECLINED) THE PRIVACY POLICY INFORMATION STATEMENT REGARDING THE MANAGEMENT OF MY PROTECTED HEALTH INFORMATION BY THE OFFICE OF KATHRYN M. GARDNER, M.D. UNDER THE REGULATIONS OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996.

SIGNATURE_____DATE_____