

KATHRYN M. GARDNER, M.D.

NEW PATIENT INFORMATION

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 _____

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 _____

PATIENT MEDICAL AND EYE HISTORY

Patient Name _____ DOB _____ Date _____

Medications and Supplements _____

Eye Medications _____

Medication Allergies _____

Family History Diabetes ___ Hypertension ___ Glaucoma ___ Macular Degeneration ___ Retinal Detachment ___ Strabismus (crossed eyes), lazy eye ___ Blindness _____

Eye History (Surgeries, Treatment) _____

Current Eye Symptoms _____

Review of Systems and Current Medical Conditions

Constitutional (fever, sleep disorders, weight change) _____

Ear/nose /mouth/throat (hearing, sinus, dry mouth) _____

Cardiovascular (heart disease, hypertension, arrhythmia) _____

Respiratory (asthma, smoking history) _____

Gastrointestinal (ulcer, reflux, hepatitis, diarrhea) _____

Genitourinary/Kidney _____

Skin (rash, dryness) _____

Muscles and Joints _____

Neurological (headache, dizziness, seizures, strokes) _____

Endocrine (thyroid, pituitary, menopause) _____

Allergy/Immunology (hay fever, allergies, autoimmune disease) _____

Hematologic/Oncologic (cancer, AIDS, blood clotting disorder) _____

Psychiatric (depression, anxiety) _____

