OVERLAND PARK
EYE CENTER

Dr. Joseph M. Schwerdtfeger • Dr. Kristin M. Pierce

WELCOME TO OUR OFFICE
PLEASE COMPLETE OUR
PATIENT INFORMATION FORM

Today's Date _____

Patient Information

Last _____
First_____ MI_____
If Child, Parent's Name_____
Street_____
City_____
State_____ Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Date of Birth _____ Age _____
Sex ☐ Male ☐ Female
Patient's SSN _____
Email _____
Employer _____
Occupation _____
Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed
Number of Children _____
Ages of Children_____

Are any of your family members seen as patients in our office? ☐ Yes ☐ No
If Yes, Who?_____
_____

What is the primary reason for this visit?
_____
_____

Our practice continues to grow through the kind referral of our satisfied patients. Whom may we thank for referring you to our office?

_____

If not referred, how did you choose our Office?

☐ Another Doctor:_____
☐ Insurance List
☐ Saw Sign/Building
☐ Newspaper/Radio/TV
☐ Yellow Pages: Which directory?_____
☐ Web Page: Which Site?_____
☐ Other_____

Insurance Information

Please note that some insurance plans do NOT cover the Contact Lens Fitting Fee

Vision Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Date of Birth_____

Primary Medical Insurance
_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Date of Birth_____

Lifestyle Questions

DO you..... (check box if your answer is yes)
☐ ..work at a computer?
☐ ..plan on purchasing new glasses today?
☐ ..think you might benefit from thinner, lighter lenses?
☐ ..have an interest in contact lenses?
☐ ..spend time outdoors? How much?
☐ ..have or want prescription sunwear?
☐ ..want information on Laser Correction Surgery?

Have you ever experienced or been treated for any of the following?

☐ Blurry Vision	☐ Double Vision
☐ Cataracts	☐ Floaters/Spots
☐ Crossed/Turned Eye	☐ Iritis/Uveitis
☐ Eye Infections	☐ Lazy Eye
☐ Flashes of light	☐ Dry Eye
☐ Glaucoma	☐ Grittiness
☐ Headaches	☐ Burning/Itching
☐ Migraine Headache	☐ Seasonal Allergies
☐ Macular Degeneration	☐ Tearing/Watery Eyes
☐ Retinal Detachment	☐ Sun Sensitivity

☐ Other_____
_____

7500 W. 119th St., Overland Park, Kansas 66213
Phone: 913.345.2020 • Fax: 913.345.2662 • www.opeyecenter.com

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The information in this confidential case history form is critical to the evaluation of your vision and health

Patient Medical History

Family Physician _____
City_____
State_____
Date of Last Exam_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, Vitamins, & birth control pills_____
_____
_____

Allergies to medications? ☐ Yes ☐ No
If so, what medications?
_____

Are you pregnant or nursing? ☐ Yes ☐ No

Have you had any surgeries? ☐ Yes ☐ No
What kind/ When?_____
_____

Do you use cigarettes/tobacco, alcohol, or other substances? ☐ Yes ☐ No Frequency_____

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Allergies	☐	☐
Arthritis	☐	☐
Blood/Lymph	☐	☐
Bronchitis	☐	☐
Cancer	☐	☐
Cholesterol	☐	☐
Diabetes	☐	☐
Digestive	☐	☐
Ears/Nose/Throat	☐	☐
Endocrine	☐	☐
Eczema/Rashes	☐	☐
Fatigue	☐	☐
Fevers	☐	☐
Genitourinary (Urinary)	☐	☐
High Blood Pressure	☐	☐
Integumentary (Skin)	☐	☐
Kidney	☐	☐
Muscle/Bone	☐	☐
Neurological	☐	☐
Psychological	☐	☐
Respiratory	☐	☐
Sinus	☐	☐
Throat Infections	☐	☐
Thyroid	☐	☐
Unusual weight loss/gain	☐	☐

Patient Eye History

Date of Last Eye Exam_____
Previous Doctor's Name_____

Do you currently wear glasses? ☐ Yes ☐ No

☐ Single Vision ☐ Bifocal/ Trifocal ☐ Progressive

CONTACT LENSES

Are you interested in a contact lens evaluation today at an additional fee? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No
What kind?_____
Solutions used?_____
What kind of contact lenses would you prefer?

☐ Monthly ☐ Two Week ☐ Daily ☐ Colored

Family Medical/Eye History

Is there a family history of any of the following

	Relationship (Mother, Father, Grandparent, Sibling)
Blindness	☐_____
Cataracts	☐_____
Corneal Problems	☐_____
Diabetes	☐_____
Glaucoma	☐_____
Heart Disease	☐_____
Lazy Eye	☐_____
Macular Degeneration	☐_____
Retinal Problems	☐_____

Insurance Consent/Privacy Statement

ALL PATIENTS ARE RESPONSIBLE FOR PAYMENT IN FULL AT THE TIME OF SERVICE. Insurance companies do not guarantee payment of benefits. Patients are financially responsible for all charges whether or not paid by insurance. This is a contract between you and your insurance company... Not Overland Park Eye Center.

Overland Park Eye Center has my consent to the release of medical records. I understand that my medical records are confidential. I understand that by signing this consent form I am allowing my medical information to be released for the purpose of Health Care Operations (including, but not limited to, provider review functions, claims payments, and quality assessments). I also understand that I may revoke this consent by written request at any time. If revoked , it is understood by all parties that all information released prior to notification of such revocation was made by my consent.

I have read the statement above and in signing this document give my consent to release my medical records and information. I do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this consent and agree to pay any charges not covered by insurance.

I have received the Notice of Privacy Practices and I have had the opportunity to review it.

_____
Patient/Guardian Signature Date

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