Welcome to Kilgo Eye Care

Thank you for choosing **Kilgo Eye Care** for your vision care. Our mission is to provide excellent service with a personal touch in a friendly and relaxed environment for your entire family.   We take pride in our professional, knowledgeable and friendly staff. Our focus is on getting to know our patients and exceeding their expectations.

Enclosed you will find a Welcome to our Office form and a Health History form. We provide these copies so you can complete them at home. Please take the time to fill out these forms completely and bring them with you to your appointment.

Please remember to bring the following with you to your appointment:

1. The completed Welcome to the Office form and Health History form
2. Your glasses including computer glasses and sunglasses
3. Your insurance cards- medical and vision
4. A safety glasses form with all required sections filled out (if applicable)

We look forward to seeing you.

Sincerely,

Susanne S. Kilgo, OD

Today's Date_____________

Patient Name____**Nickname**_________________
First MI Last

Mailing Address____
Street City State Zip

Home Phone_________________ **Cell Phone**_______________ **May We [ ] Leave a Message [ ] Text**

Email____

Date of Birth_______________**Age**__________ **Gender**_____________________________________

Occupation____________________________**Employer**_____________________________________

Marital Status [ ] Single [ ] Married [ ] Widowed How did you hear about our office?_____________

INSURANCE INFORMATION

I understand that Kilgo Eye Care will bill most insurance carriers and that all copay and deductible amounts are due at the time of service.

Signature____**Date**_________________

HIPAA Compliance

The HIPAA notice describes how health information about you may be used and disclosed and how to get access to this information. Signing below indicates that you have seen our Notice of Privacy Practices. Please let us know if you would like a copy of our HIPAA privacy policy and one will be provided for you.

Signature____**Date**_________________

Release of Privileged Medical Information

I give Kilgo Eye Care permission to speak with the following people regarding my personal health information. I understand that sharing health information with specialists and other health providers is necessary and not excluded by this form. This form gives Kilgo Eye Care permission to share health information with nonprofessionals such as family and friends.

Name____**Relationship**____________________

Name____**Relationship**____________________

Signature____**Date**__________________

HEALTH HISTORY FORM

Patient Name:____**Date:**_____________
Primary Care Physician__________________________________

Medical History: Check any medical conditions you have

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Stroke
- ❑ Cancer(type)___________
- ❑ COPD
- ❑ Heart attack
- ❑ Depression
- ❑ Diabetes. Year diagnosed_____
- ❑ Epilepsy
- ❑ Acid reflux
- ❑ High blood pressure
- ❑ Hearing loss
- ❑ HIV/AIDS
- ❑ High cholesterol
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Leukemia
- ❑ Lymphoma
- ❑ Acne rosacea
- ❑ Crohn's disease
- ❑ Fibromyalgia
- ❑ Multiple sclerosis
- ❑ Parkinson's
- ❑ Rheumatoid arthritis
- ❑ Sjogren's disease
- ❑ Sleep apnea
- ❑ Other____

Ocular History: Check any ocular conditions you have

- ❑ Allergic conjunctivitis/itching
- ❑ Strabismus/lazy eye
- ❑ Cataracts
- ❑ Macular degeneration
- ❑ Dry Eyes
- ❑ Glaucoma
- ❑ Floaters
- ❑ Diabetic retinopathy
- ❑ Ophthalmic migraine
- ❑ Retinal tear/detachment
- ❑ Wears glasses
- ❑ Wears contact lenses
- ❑ Other____

FAMILY HISTORY:	Mother	Father	Sister	Brother	Grandmother	Grandfather
Diabetes	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑
Macular Degeneration	❑	❑	❑	❑	❑	❑

List all Medications and supplements:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________
9. ____________________

List medications you are allergic to:____

List any eye surgeries:____

List major surgeries:____

SOCIAL HISTORY: Alcohol use: ❑ None ❑ Occasionally ❑ Daily
Smoking: ❑ Never ❑ Current smoker,packs per day___❑ Former smoker
Females: Currently Pregnant: ❑ Yes ❑ No Currently Nursing: ❑ Yes ❑No