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Aker Kasten Eye Center

Welcome to the Aker Kasten Eye Center!

On behalf of the doctors and staff, we would like to thank you for choosing the Aker Kasten Eye Center for your eye care needs! Enclosed are some forms you will need to complete prior to your appointment with us.

Please be sure to bring the following with you the day of your appointment:

1. **ALL NEW PATIENT FORMS IN THIS PACKET, COMPLETED.**
2. **INSURANCE CARDS** and **PHOTO ID CARD.**
3. **A LIST OF MEDICATIONS AND DAILY DOSAGES** you are currently taking.

In order to expedite your visit, please fax or mail to us the **Patient Information and Medical History forms** at:

Aker Kasten Eye Center
1445 NW Boca Raton Blvd.
Boca Raton, FL 33432
FAX: 561.338.7785

PLEASE NOTE:

Your eyes will be dilated and your initial visit may be 2-3 hours

If you are considering cataract surgery, we will be unable to perform necessary testing unless you discontinue wearing your contact lenses according to the following protocol:

Gas permeable lenses – 2 weeks
Hard lenses – 2 weeks
Soft contact lenses – 1 week

In some cases, contact lenses may be required to be left out longer and a second visit may be necessary.

Again, we welcome you as a new patient and look forward to meeting you!

Aker Kasten Eye Center

PATIENT INFORMATION

PLEASE PRINT AND FILL OUT COMPLETELY

Date _____ **Mr. Mrs. Ms. Rev. Dr. of:** _____ **Date of Birth:**_____

First _____ **M.I.** ____ **Last** _____ **Spouse:** _____

Local Street Address _____ **Apt #** _____

City _____ **State** _____ **Zip** _____

Name of Development_____ **Is this a Nursing Home?** ☐ **Yes** ☐ **No**

Patient's Email Address: _____

Phone H ( ) _____ - _____ Cell ( ) _____ - _____ Work ( ) _____ - _____

Please check one: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline

Please check one: ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐White ☐Other ☐Decline

Contact person for messages (family or friend)

Name: _____ *Phone: ( ) _____- _____*

Out of Area Address: From_____To_____

Street_____ City_____ State _____ Zip _____

PHARMACY _____ ADDRESS_____ PHONE _____

How were you referred to this office (please check all that apply)?

☐ Your eye doctor
☐ Your Primary care doctor
☐ Friend/Reputation
☐ Radio Advertisement
☐ Magazine Advertisement
☐ Internet/Website
☐ Caridad Clinic
☐ Other _____

Primary Care Physician: _____ **Phone: ( ) _____ - _____**

Name of Eye Doctor: _____ **Phone: ( ) _____ - _____**

Patient's Rights of Disclosures: In general, the HIPAA privacy rule gives the individuals the right to request restriction on uses and disclosures of health information. The individual is also provided the right to request confidential communications of health information be made by alternative means.

List all persons in your household who, in your absence, may make requests on your behalf, and with whom we may speak regarding your medical records.

_____ _____

_____ _____

Fax #: 561-338-7785

MEDICAL HISTORY

Patient Name: _____ Date: _____

Medical History

Yes No

- ☐ ☐ Hypertension # of years _____
- ☐ ☐ Liver
- ☐ ☐ Cardiac Disease / Chest Pain
- ☐ ☐ Cholesterol
- ☐ ☐ Thyroid Disease
- ☐ ☐ Stroke / TIA
- ☐ ☐ Latex Allergy
- ☐ ☐ Cancer type: _____
- ☐ ☐ Pulmonary Disease

Yes No

- ☐ ☐ Kidney
- ☐ ☐ Diabetes
  Last blood sugar _____ # of years _____
- ☐ ☐ Arthritis
- ☐ ☐ Infectious Diseases
  ☐ Hepatitis ☐ HIV ☐ TB ☐ MRSA
- ☐ ☐ Other: _____

Medications you are currently taking:

Medication	Dose	Frequency

Medication	Dose	Frequency

Medication	Dose	Frequency

Drug Allergies and Reactions: **HAVE YOU EVER TAKEN FLOMAX, AVODART OR JAYLN?** ☐ Yes ☐ No

_____ _____ _____

_____ _____ _____

Your Eye History: (Have you been diagnosed with any of the following conditions in the past?)

Yes No

- ☐ ☐ Cataracts _____
- ☐ ☐ Retinal Disease_____
- ☐ ☐ Glaucoma _____

Yes No

- ☐ ☐ Eye Injury _____
- ☐ ☐ Any Other Eye Disorders: _____

☐ **Cataract Surgery date** Right _____ Left _____

☐ **Yag Laser date** Right _____ Left _____

☐ **Retinal Surgery date** Right _____ Left _____

☐ **LASIK Surgery date** Right _____ Left _____

Surgical History and Hospitalizations within the last year:

Type of surgery / reason for admission	Surgery/admission date	Type of surgery / reason for admission	Surgery/admission date
_____	_____	_____	_____
_____	_____	_____	_____

Family History **(Mother, Father, Grandparent, Sibling)**

Has any member of your family had these diseases (circle all that apply)? ☐ Yes ☐ No ☐ Unknown

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease,

Social History

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

Do you smoke? ☐ Yes ☐ No If yes, how much? How many years?

Aker Kasten Eye Center

Insurance Information

Our office accepts Medicare assignment. The 20% co-payment will be collected at the time of your office visit. If you participate in MediGap, your supplementary insurance will automatically be submitted for you by your insurance company

Patient Name: _____ Date: _____

Patient's Social Security Number: _____

Primary Insurance: _____ Policy #: _____

If the primary insurance is in the name of someone other than the patient, we need the following:

Name of Insured: _____

Social Security #: _____ DOB: _____

Secondary Insurance: _____ Policy #: _____

If the secondary insurance is in the name of someone other than the patient, we need the following:

Name of Insured: _____

Social Security #: _____ DOB: _____

Patient Authorization

Insurance Lifetime Authorization: I request that payment of my insurance benefits be made to the physicians of Aker Kasten Eye Center. I authorize medical information be released to the insurance company to determine these benefits for services.

Fee Consent: I assume full responsibility for all charges at Aker Kasten Eye Center.

Patient's Signature: _____

Witness: _____ Date: _____

PLEASE HAVE YOUR INSURANCE CARD READY FOR US TO MAKE A COPY.

Fax #: 561-338-7785

Aker Kasten
Eye Center

DIRECTIONS

1445 N.W. BOCA RATON BLVD.
561-338-7722

FROM I-95

1. TAKE I-95 TO GLADES ROAD (EXIT 45)
2. GO EAST TO BOCA RATON BLVD
   (APPROXIMATELY 2 MILES)
3. MAKE A LEFT ON BOCA RATON BLVD.
4. AKER KASTEN IS SECOND BUILDING ON LEFT.
   (CORNER OF BOCA RATON BLVD. AND N.W. 15 STREET)

FROM FEDERAL HIGHWAY

1. TAKE FEDERAL HIGHWAY. TO GLADES ROAD
2. GO WEST ON GLADES ROAD.
3. TURN RIGHT AT BOCA RATON BLVD.
4. AKER KASTEN IS SECOND BUILDING ON LEFT
   (CORNER OF BOCA RATON BLVD. AND N.W. 15 STREET)

FROM CONGRESS or MILITARY TRAIL

1. TAKE CONGRESS/MILITARY TRAIL TO YAMATO RD
2. GO EAST (LEFT) ON YAMATO TO NW BOCA RATON BLVD.
3. TURN RIGHT ONTO NW BOCA RATON BLVD
4. AKER KASTEN WILL BE APPROX 1½ MILES ON THE RIGHT.

Aker Kasten
Eye Center

Acknowledged Receipt of

Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the information provided.

In accordance with your rights under, and subject to certain restrictions imposed by HIPAA, you may inspect your PHI in the designated record set maintained by the Aker Kasten Eye Center for as long as the PHI is maintained in the designated record set. Persons authorized to obtain verbal/written information of my protected health information: _____

_____ _____

Patient Name (please print) Signature of Authorized Representative

X _____ _____

Patient Signature Witness to Relative/Guardian

X _____

Witness to Patient Signature

Aker Kasten Eye Center

Please Read and Sign
Before Your Visit

You may have a REFRACTION performed during your visit with us today. The refraction gives our physicians very important information about the condition of your eyes. It is critical in assessing the effect of any corneal changes, cataracts, retinal conditions or optic nerve disease found in the course of your exam. It is also the most precise method in which our physicians can determine that your eyes are corrected for the best vision possible.

If you are a new patient at our Center, a baseline refraction will likely be performed today if you are not seeing 20/20 with your present correction. You may or may not be given a prescription for new glasses based on the results of your refraction.

There will be a **$40 charge** for the refraction. If you are on Medicare, this is an out-of-pocket expense, as **refractions are not covered by Medicare*.** If you have private insurance, we will collect the $40 from you today and submit the charge to your insurance company. You will then be reimbursed for any amount collected from your insurance company.

Please inquire at the front desk if you have any questions.

I have read and I understand the above policy regarding refractions:

_____ _____

Patient Signature Date

*Medicare guideline states: “Routine eye examinations for the purpose of prescribing, fitting or changing eye glasses or contact lens(es); eye refractions are non-covered.”