ALAN B. AKER, MD
ANN G. KASTEN AKER, MD
JONATHAN E. AKER, MD
ANUP KUBAL, MD

Aker Kasten Eye Center

VITO J. GUARIO, OD
KELLI F. WOLPER, OD
ALEXIS C. SEIDEL, OD

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) 980-7711

PLEASE NOTE:

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

CONTACT LENS WEARERS: 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 suggested time parameters:

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.

Please use artificial tears prior to your visit with us

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

1445 NW BOCA RATON BLVD
BOCA RATON, FL 33432

Aker Kasten Eye Center

PHONE (561) 338-7722
FAX (561) 980-7711

PATIENT INFORMATION

PLEASE PRINT AND FILL OUT COMPLETELY

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

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

Street Address _____ City _____ State _____ Zip_____

Is this a Nursing Home/Assisted Living Facility? ☐ Yes ☐ No

Social Security #: _____ Email:_____

Phone: Land Line_____ Cell Phone _____ Work _____

***My cell phone number may be used for Aker Kasten appointment reminders:* ☐ Yes ☐ No

Reason for my visit: _____

Out of Area Address: From_____ to _____

Street _____ City _____ State _____ Zip_____

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

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

INSURANCE

Primary Insurance Co _____ Policy Holder: _____

Primary Holder ID# _____ Policy Holder Date of Birth: _____

Secondary Insurance Co _____ Policy Holder: _____

Primary Holder's ID# _____ Policy Holder Date of Birth: _____

DOCTORS

Name of Primary Care Physician: _____ Phone: _____

Name of Eye Doctor: _____ Phone: _____

REFERRAL INFORMATION

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

☐ Your Eye Doctor ☐ Your Primary Care Physician ☐ Caridad Clinic/Community Health ☐ Friend

☐ Other _____

PHARMACY

Address _____ Phone: _____

PATIENT NAME (Please print) First _____ M.I. _____ Last _____

FINANCIAL CONSENTS/AUTHORIZATIONS

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.

ACKNOWLEDGEMENT OF SELF PAY: I understand that if at any time my insurance does not cover my services, I agree to pay all charges.

REFRACTIONS: If I am a new patient at the Center and have not been referred by my optometric physician, a baseline refraction will likely be performed on my first visit if I'm not seeing 20/20 with my present correction. I may or may not be given a prescription for new glasses based on the results of my refraction. If am an established patient and my vision has decreased since my last refraction, a new refraction is recommended. If I am on Medicare, **there will be a $55 charge for the refraction since refractions are not covered by Medicare**. If I have private insurance, I understand you will collect the $55 from me and submit the charge to my insurance company. I will then be reimbursed for any amount collected from my insurance company. *I understand that a refraction done in this office is a non-covered service and payment is expected from me at the time of service.*

I hereby acknowledge that I have read, understand and accept the above statements and policies.

Patient Signature: _____ Date: _____

PLEASE HAVE YOUR INSURANCE CARD AND PICTURE ID READY FOR US TO MAKE A COPY

PATIENT PRIVACY

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that a copy of the Notice of Privacy Practices has been made available to me and that I have read (or had the opportunity to read if I so chose) the information provided. A copy of this document is available on the Aker Kasten website at https://www.akerkasten.com/our-practice/government-compliance/. In accordance with my rights under, and subject to certain restrictions imposed by HIPAA, I may inspect my 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.

SHARED INFORMATION AUTHORIZATION

☐ I do NOT wish to share my information with anyone at this time.

☐ I DO authorize the sharing of the following information with those listed below:

☐ All Information ☐ Appointment/Demographic ☐ Medical information ☐ Billing Information

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

This authorization will remain in effect unless terminated by me in writing.

I hereby acknowledge the above to be true and accurate.

Patient Signature: _____ Date: _____

Aker Kasten Eye Center

MEDICAL HISTORY

Patient Name _____ Date: _____

MEDICAL HISTORY

Yes	No		Yes	No	
☐	☐	Hypertension # of yrs _____	☐	☐	Pulmonary Disease
☐	☐	Liver	☐	☐	Kidney
☐	☐	Cardiac Disease/Chest pain	☐	☐	Diabetes
☐	☐	Cholesterol			Last blood sugar _____ # of yrs _____
☐	☐	Thyroid Disease	☐	☐	Arthritis
☐	☐	Stroke / TIA	☐	☐	Infectious Diseases
☐	☐	Latex Allergy			☐ Hepatitis ☐ HIV ☐ TB ☐ MRSA
☐	☐	Cancer Type: _____	☐	☐	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		Yes	No	
☐	☐	Cataracts	☐	☐	Eye Injury
☐	☐	Glaucoma	☐	☐	Any other Disorders _____
☐	☐	Retinal Disease			
☐		**Cataract Surgery Date** Right _____ Left _____	☐		**Retinal Surgery Date** Right _____ Left _____
☐		**YAG Laser 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, Arthritis
Other heritable 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? _____

FAX #: (561) 980-7711

Aker Kasten Eye Center

SPEED Questionnaire

Office Use Only
Total SPEED Score (Frequency + Severity) _____ /28

Name: _____ DOB: _____ Sex: ☐ Male ☐ Female

How **FREQUENTLY** do you experience the following dry eye symptoms?

Symptoms	Never 0	Sometimes 1	Often 2	Constant 3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

How **SEVERE** are your dry eye symptoms?

Symptoms	No Problems 0	Tolerable 1	Uncomfortable 2	Bothersome 3	Intolerable 4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

WHEN have you experienced dry eye symptoms?

☐ Today ☐ Within the past 72 hours ☐ Within the past 3 months

Activities	Yes	No
Do you have difficulty reading?		
Do you have difficulty using a computer?		
Do you have difficulty driving?		
Do you have difficulty watching television?		
Do you have difficulty wearing contact lenses?		
Do you have difficulty being outdoors?		
Do your symptoms worsen throughout the day?		

Do you use drops and/or ointment? ☐ Yes ☐ No Name of Product: _____ Frequency: _____

Do you experience blurred or fluctuating vision? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No How long can you wear contacts comfortably? _____

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.