ALAN B. AKER, MD
ANN G. KASTEN 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) 338-7785**

## 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) 338-7785


# 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 _____

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# _____ Group #: _____

Secondary Insurance Co _____ Policy Holder: _____

Primary Holder's ID# _____ Group #: _____

## 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 |
|---|---|---|
| | | |
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| | | |

| Medication | Dose | Frequency |
|---|---|---|
| | | |
| | | |
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| | | |
| | | |

## 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) 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.