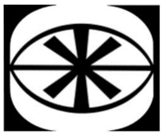

Harkins Eye Clinic

Lori A. Harkins, M.D., P.C.
830 N Alpha Street Grand Island, NE 68803
Phone 308-384-9148, Fax 308-384-9158
www.harkinseyeclinic.com

Date: ________________

Name (prefix & suffix): ____

Sex: M F **Responsible Party** (Self, Parent, or POA):______________________________

Address: ____

City: ______________________ **State** _______ **Zip Code**: __________

Ethnicity: _____Hispanic or Latino _____Non-Hispanic or Latino _____Unknown _____Declined to Specify

Race: _____ American Indian or Alaska Native _____Asian _____Black or African American _____White
_____ Native Hawaiian or Other Pacific Islander _____Other Race _____Declined to Specify

Preferred Language: ___________**Preferred Phone #** __________________**Cell #**_____________________

Voice reminder to this number(home) Yes/No **Text reminder to this number(cell):** Yes/No **Both:** Yes/No

Email:____ Work # _____________________________

Marital Status (circle): Single Married Separated Widowed Divorced

Date of Birth: ______/______/________ **Social Security #**: ________-_______-_________

Employer: ________________________________ **Occupation:** ____________________________________

Spouse: ______________________________ **Spouses Occupation:** _________________________________

Emergency Contact Name: __________________________ **Emergency Phone:** _______________________

Name of Primary Insurance: __________________**Name of Secondary Insurance:**____________________

Insured's Name, Date of Birth, & SSN: ____

Primary Care Physician: ____

Were you referred by someone, if YES, by who? : ____

If under the age of 18, parents name and phone: ____

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this form and have completed all the blanks. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Signature ____**Date** _____________________

Parent (**if minor**) ____**Date** _____________________

CONTINUED ON BACK

NOTICE OF PRIVACY PRACTICES RECEIPT

I have been made available copy of the Notice of Privacy Practices for Harkins Eye Clinic containing a complete description of the uses and disclosures of my health information. I understand that Harkins Eye Clinic has the right to change its Notice of Privacy Practices if necessary and that I may contact this office at any time to obtain a current copy of the Notice.

Patient Signature: ____

Representative Signature: ____

Relationship to Patient: ____

Date Signed: ____

COMMUNICATION RELEASE FORM

I hereby give permission to communicate with the following individuals regarding my examination, treatment, and statement of account at Harkins Eye Clinic.

Please list names and phone numbers of all the people you would like to share your protected health information with:

____

____

____

____

____

____

____

Patient Signature ____ Date____________________

Personal Representative (if applicable) ____

HARKINS EYE CLINIC **Name________________________**

Have you ever been diagnosed with the following medical conditions and/or currently being treated for: Please circle all that apply:

Cataracts
Macular Degeneration
Glaucoma
Lazy Eye
Dry Eye
Droopy Eyelids
Eyelid Inflammation
Heart Disease
Coronary Artery Disease
Atrial Fibrillation
COPD
Heart Attack
Hypertension
High cholesterol

Anxiety
Depression
Asthma
Sleep Apnea
Emphysema
Tuberculosis
Dementia
Stroke
Diabetes
Migraine w/w/o visual disturbance
Kidney Disease
Thyroid Disease
Cancer
Arthritis (Rheumatoid or degenerative)

Methicillin Resistant Staph Aureus (MRSA)
HIV/AIDS
Hepatitis A, B, or C
Osteoporosis
Obesity
Diverticulitis
Acid Reflux (GERD)
Hearing Loss

Review of Systems: Do you **CURRENTLY** have any of the following, **please circle all that apply:**

Cardiovascular
Chest Pain
Irregular Heartbeat
Shortness of Breath

HEENT
Dizziness
Hearing Loss
Hoarseness
Ringing in Ears
Sore Throat

Musculoskeletal
Back pain
Joint pain
Muscle aches
Stiffness
Swelling

Respiratory
Cough
Trouble breathing
Wheezing

Blood Pressure Control
Good BP control
Borderline BP control
Poor BP control
Unknown BP control

Constitutional
Fatigue
Fever
Night Sweats
Weakness
Weight Loss

Hematologic
Bleeding
Bruising
Tender Nodes

Neurological
Balance Problems
Headache
Numbness
Tingling

Skin
Hair loss
Rash
Skin Lesions

Diabetes Control
Good DM control
Borderline DM control
Poor DM control
Unknown DM control

Genitourinary
Genital discharge
Genital lesions
Painful Urination
Urgency

Metabolic
Cold intolerance
Excess hunger
Excessive thirst
Frequent urination
Heat intolerance

Psychiatric
Anxiety
Depression
Insomnia
Irritability
Nervousness

Allergy
Itching
Hives
Chronic Runny Nose
Seasonal Allergies

Are you pregnant
No
Yes(how many wks)

Gastrointestinal
Diarrhea
Vomiting
Heartburn
Abdominal pain

CONTINUED ON BACK

PAST SURGICAL / LASER PROCEDURES (EYE)

PLEASE CHECK ALL THAT APPLY WITH APPROXIMATE DATE OF PROCEDURE & BY WHOM.

Cataract Surgery ________________________ Laser (type) ______________________

Glaucoma Surgery________________________ Muscle surgery ____________________

Retinal Detachment______________________ Retinal Tear _______________________

LASIK / PRK ___________________________ RK _____________________________

Eye Injections (# of injections & dates) ____

PAST SURGICAL PROCEDURES (NON-EYE related) Please list any major surgeries (joint replacement, heart, etc.) you may have had with approximate date.

____

____.

FAMILY HISTORY: **Please Circle any of the conditions that may apply in your family.**

Glaucoma Diabetes Heart Dz. Stroke Corneal Dz. Thyroid Dz.

Macular Degeneration Retinal Tear / Detachment Cataracts Lazy Eye

ALLERGIES: **(With reaction, if known)** _______________________________________

____.

Please give a current list of medications with dosing and milligrams to the front office to copy or please list.

____

____.

SOCIAL HISTORY (PLEASE CIRCLE ALL THAT APPLY)

Smoke Alcohol Recreational Drugs None

Do you wear contact lenses? If so what type, brand, power, and base curve (BC).
Please list.

____

I have read all the information on this form and have completed all the blanks. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

PATIENT SIGNATURE ______________________________ **DATE** ______________

PARENT (if minor) ______________________________ **DATE** ______________