

MATTHEW D. KAY, M.D., F.A.
PATIENT INFORMATION SHEET

Name: _____
(First) (MI) (Last)

Sex: (circle) Male Female Social Security No: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Home Phone: (____) _____ Work Phone: (____) _____

Date of Birth: _____

Referring Physician: _____ Phone No.: _____

Family Doctor: _____ Phone No.: _____

Marital Status (circle) Single Married Other

Occupation: _____ Employed by: _____

If student please indicate (circle): Full Time Student Part Time Student

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Ins: _____

Policy No.: _____ Policy No.: _____

Group No.: _____ Group No.: _____

Name of Policy Holder: _____ Name of Policy Holder: _____

Date of Birth of Policy Holder: _____ Date of Birth of Policy Holder: _____

PLEASE READ AND SIGN: PATIENT FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for charges not covered by this assignment, including any insurance or co-payment, or for any charges, which the insurance carrier declines to pay. I authorize and request my insurance company to pay directly to the doctor, or ophthalmic group, insurance benefits otherwise payable to me. I understand that if for any reason my insurance company does not pay my bill within 90 days I will be fully responsible for payment. Any returned check will incur \$25.00 minimum returned check fee. In the event the account become delinquent and is turned over to a collection agency, I am responsible for any collection, court, or attorney fees. I also acknowledge that it is my responsibility to fully understand the rules and regulations of my insurance company.

Sign Here: _____ Date: _____

Matthew D. Kay, M.D.
Practice limited to Neuro-ophthalmology

GENERAL INFORMATION

DILATION OF EYES

In order to perform a complete *eye* examination, it will be necessary to put drops in your eyes, which will dilate them. Dilation means that the pupils will become enlarged for a period of time letting in more light and potentially blurring vision, particularly at near. A few patients have expressed concern regarding their ability to function after dilation. It has been our experience that the near vision is affected far more than the distance, and that most individuals are able to "get around", although some caution may be necessary in the presence of any decreased vision. Please note that dilation is necessary in order to give the doctor a full and enlarged view of the optic nerve, retina, or back of the eye. This is vital in evaluating and diagnosing the effects of many types of conditions including, neuro-ophthalmological disorders, retinal diseases, and glaucoma. If you are driving yourself and are concerned about dilation, you can always reschedule an appointment for the dilated portion of the examination when you have someone to drive you home. If you have any further concern regarding this, please do not hesitate to let us know. **Please wear your sunglasses when leaving the office until the effects of the dilation wear off. If needed we have sunglasses available upon request.**

RELEASE OF INFORMATION

I authorize Matthew D. Kay, M.D. to release any information, including the diagnosis and the records of any treatment or examination rendered to my dependent or me during the period of such eye care, to individuals such as third party payers and/or health practitioners. This includes, but is not limited to, insurance companies, workers' compensation, welfare funds or the patient's employer.

EMERGENCY INFORMATION

Dr. Matthew Kay should always be contacted for any significant change in visual function between scheduled office appointments. If you are having an emergency while Dr. Matthew Kay is out of town please see your general ophthalmologist, your neurologist, or go to the Bascom Palmer Eye Institute Emergency Room.

NATURE OF PRACTICE

Dr. Matthew Kay has an exclusively out-patient neuro-ophthalmology practice. In some circumstances, your condition may require admission to a hospital or other facility. If this is necessary, your care will be transferred to an internist/general medical physician, general neurologist, general ophthalmologist, general surgeon, etc. It is likely that a neuro-ophthalmologist will not be available to you in such a setting.

ACKNOWLEDGEMENT

I certify that I have read and understand this general information form.

X _____ Date: _____
Signature of patient (or parent if a minor)

MATTHEW D. KAY, M.D.
PRACTICE OF NEURO-OPHTHALMOLOGY

PATIENT CONSENT FORM

The notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review this Notice before signing this Consent. The terms of the Notice may change. If the Notice is changed, you may obtain a revised copy by contacting our office.

You have the right to request my Practice to restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to the use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- My Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent
- I authorize Dr. Kay to speak with the following individuals regarding my medical records and care: _____

Signature of Patient or
Legal Representative: _____

Print Name: _____ Date: _____

Relationship to Patient (if other than patient): _____

In front of _____ Print Name: _____

Signature- Office Representative

Office Representative

Today's date _____

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Birthdate: _____
 Name of referring physician: _____ Phone: _____
 Address: _____

REVIEW OF SYSTEMS

Do you presently have any problems in the following areas? If "YES", give an explanation. Please list other medical conditions not specifically mentioned on this form.

	YES	NO	EXPLANATION OF PROBLEM
Constitutional			
Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight loss (If yes, how much?)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Malaise	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, nose, mouth, throat			
Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry throat/mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Decreased hearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular (heart/blood vessels)			
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest pain/angina	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory (lungs/breathing)			
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal (stomach/intestines)			
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary (genitals/kidney/bladder)			
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prostate enlargement	<input type="checkbox"/>	<input type="checkbox"/>	_____
Menstrual abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal			
Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Integument (skin/breast) (include skin cancer)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological			
Cerebrovascular accident	<input type="checkbox"/>	<input type="checkbox"/>	_____
Transient ischemic attacks	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other headache	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____

	YES	NO	
Endocrine			
Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hematological/Lymphatics			
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lymphoma/Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic and Immunologic			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____

PAST HISTORY

List any medications you take (include aspirin): _____

List any eye medications you take: _____

List any major illnesses and injuries you have had in the past: _____

List any surgeries you have had in the past: _____

Do you have allergies to any medications: YES NO

If yes, list medications and type of reaction: _____

FAMILY HISTORY

	YES	NO	
DISEASES			
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraine headache	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer (list type, if known)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY

Current occupation: _____

Do you drive?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have visual difficulty when driving?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a problem with night vision?	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently wear glasses?	<input type="checkbox"/>	<input type="checkbox"/>

IF YES, how long have you had the current pair? _____

Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
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If YES, how many glasses a day? _____

Do you smoke?
 IF YES, of QUIT, how many packs a day and for how many years? _____

Do you have a healthy diet?	<input type="checkbox"/>	<input type="checkbox"/>
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History reviewed No changes Additions and noted above

Physician's Signature: _____ Date: _____