Kieth J. Burkart, O.D.

A Professional Corporation

Henry A. D'Antonio, O.D.

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PATIENT INFORMATION

Date_____

SS/HIC/Patient ID#_____

Patient Name_____

Last Name

_____

First Name Middle Initial

Mailing Address_____

City_____

State_____ Zip_____

E-Mail_____

Sex ☐ M ☐ F Age_____ Birthdate_____

☐ **Married** ☐ **Widowed** ☐ **Single** ☐ **Minor**
☐ **Separated** ☐ **Divorced** ☐ **Partnered for _____years**

Occupation_____

Patient Employer/School_____

Employer/School Address_____

Employer/School Phone (__) _____

Spouse's Name_____

Birthday_____ SS#_____

Spouse's Employer_____

Whom may we thank for referring you_____

ALL INSURANCE COMPANIES

Who is responsible for this account? _____

Insurance Co. _____

Subscriber's Birthdate_____ SS#_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Insurance Co._____

Subscriber's Name_____

Birthdate_____ SS#_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage

with _____ and assign directly

to **Dr. Kieth J. Burkart, O.D. APC**, all insurance benefits, If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date Relationship to Patient

PHONE NUMBERS

Home (__) _____Cell (__) _____ Work (__) _____ Ext _____

Best time to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship_____

Home (__)_____ Cell (__)_____ Work (__) _____

Preferred Language? ☐ English ☐ Spanish

Race (Mark all that apply): ☐ American Indian ☐ Asian ☐ Black ☐ Hispanic ☐ Native Hawaiian ☐ White

Are you pregnant? _____ # of children? _____ Tobacco use? _____ Alcohol use? _____

EYE HEALTH HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following or currently experiencing:

Eye Doctor:

_____

Date of Last eye exam:

_____

Do you wear Glasses:

☐ Yes ☐ No

Do you wear Contacts:

☐ Yes ☐ No

Bloodshot Eyes	☐ Yes	☐ No		Floaters or Spots	☐ Yes	☐ No	
Blurred Vision – Distance	☐ Yes	☐ No		Glaucoma	☐ Yes	☐ No	
Blurred Vision - Near	☐ Yes	☐ No		Headaches	☐ Yes	☐ No	
Burning Eyes	☐ Yes	☐ No		Itching Eyes	☐ Yes	☐ No	
Cataracts	☐ Yes	☐ No		Light Sensitive	☐ Yes	☐ No	
Color Vision, Poor	☐ Yes	☐ No		Loss of Vision	☐ Yes	☐ No	
Crossed Eyes	☐ Yes	☐ No		Migraine Headaches	☐ Yes	☐ No	
Discharge from Eyes	☐ Yes	☐ No		Night Vision, Poor	☐ Yes	☐ No	
Dizzy Spells	☐ Yes	☐ No		Red Eyes	☐ Yes	☐ No	
Double Vision	☐ Yes	☐ No		Seeing Halos	☐ Yes	☐ No	
Dry Eyes	☐ Yes	☐ No		Seeing Flashes	☐ Yes	☐ No	
Eye Infection	☐ Yes	☐ No		Temporary Loss of Vision	☐ Yes	☐ No	
Eye Injury	☐ Yes	☐ No		Twitching Eyelid	☐ Yes	☐ No	
Eye Strain	☐ Yes	☐ No		Vision Poor	☐ Yes	☐ No	
Fainting Spells, Blackouts	☐ Yes	☐ No		Watering Eyes	☐ Yes	☐ No	

Please list previous ocular history (Surgeries or current treatment):

Treating Physician:

HEALTH HISTORY

Primary Care Physician's Name **Date of last visit:**

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also indicate if a blood relative has any of the following problems.

	Yourself		Family Members			Yourself		Family Members	
Aids/HIV	☐ Yes	☐No	☐ Yes	☐No	Hepatitis (Type_____)	☐ Yes	☐No	☐ Yes	☐No
Arthritis (Osteo or RA)	☐ Yes	☐No	☐ Yes	☐No	High Blood Pressure	☐ Yes	☐No	☐ Yes	☐No
Artificial Heart Valve	☐ Yes	☐No	☐ Yes	☐No	Kidney Disease	☐ Yes	☐No	☐ Yes	☐No
Artificial Joints	☐ Yes	☐No	☐ Yes	☐No	Lazy Eye	☐ Yes	☐No	☐ Yes	☐No
Asthma	☐ Yes	☐No	☐ Yes	☐No	Lupus	☐ Yes	☐No	☐ Yes	☐No
Bleeding	☐ Yes	☐No	☐ Yes	☐No	Migraine Headaches	☐ Yes	☐No	☐ Yes	☐No
Legal Blindness <20/70	☐ Yes	☐No	☐ Yes	☐No	Pacemaker	☐ Yes	☐No	☐ Yes	☐No
Cancer	☐ Yes	☐No	☐ Yes	☐No	Poor Color Vision	☐ Yes	☐No	☐ Yes	☐No
Cataracts	☐ Yes	☐No	☐ Yes	☐No	Retinal Disease (ARMD)	☐ Yes	☐No	☐ Yes	☐No
Chemical Dependency	☐ Yes	☐No	☐ Yes	☐No	Rheumatic Fever	☐ Yes	☐No	☐ Yes	☐No
Diabetes	☐ Yes	☐No	☐ Yes	☐No	Shingles	☐ Yes	☐No	☐ Yes	☐No
Drug Sensitivity	☐ Yes	☐No	☐ Yes	☐No	Skin Conditions	☐ Yes	☐No	☐ Yes	☐No
Emphysema/COPD	☐ Yes	☐No	☐ Yes	☐No	Stroke	☐ Yes	☐No	☐ Yes	☐No
Epilepsy	☐ Yes	☐No	☐ Yes	☐No	Thyroid Conditions	☐ Yes	☐No	☐ Yes	☐No
Eye Surgery	☐ Yes	☐No	☐ Yes	☐No	Tuberculosis	☐ Yes	☐No	☐ Yes	☐No
Glaucoma	☐ Yes	☐No	☐ Yes	☐No	Turned Eye	☐ Yes	☐No	☐ Yes	☐No
Allergic Disorders	☐ Yes	☐No	☐ Yes	☐No	Heart Condition	☐ Yes	☐No	☐ Yes	☐No

MEDICATIONS	ALLERGIES
List Provided? ☐ Yes ☐ No	**List Provided? ☐ Yes ☐ No**

Pharmacy Name: **Number:**