



EYECARE ASSOCIATES OF ANKENY

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Gregg S. Sunner, O.D.
James A. Schroder, O.D.
Jesse J. Kahnk, O. D.

WELCOME TO EYECARE ASSOCIATES OF ANKENY

We'd like to thank you for choosing our office for your eye care needs.

Please complete the enclosed patient information form to assist us in your chart preparation.

Payment is requested upon completion of examination and optical services. MasterCard, VISA, and Discover are available for your bill-payment convenience.

If you have vision or applicable medical insurance, please bring completed forms or insurance cards as well. Having a copy of benefits offered by your specific plan will also help us to outline services covered for you. Although an insurance claim has been filed, you will continue to receive statements each month as long as your account has a balance due. The charges you incur are your responsibility. EyeCare Associates is not responsible for collecting insurance claims or negotiating settlements on disputed claims. Of course, we are happy to file the claim and assist you in securing your insurance benefits.

We take pride in the quality of care we provide and want you to be fully informed of our services:

1. Besides a routine comprehensive eye examination, we have around-the-clock answering service that avails you to constant emergency services for eye injuries, infections, or other unforeseen eye-related problems.
2. Our contemporary eyewear boutique, Fashion Optique, offers the latest in ultrathin, no-line progressive bifocals, designer frame styles, and an eyewear guarantee second-to-none.
3. Specialty contact lenses for astigmatism, bifocals, and the latest in disposable lenses are professionally fit with superior success.

If you have any concerns, suggestions, or questions, please feel comfortable in addressing those to any of our staff. We feel that good communication develops confident, professional relationships.

Again, thank you for selecting our office for your eye care.

In Service to Vision,

EYECARE ASSOCIATES OF ANKENY



Welcome to EYECARE ASSOCIATES OF ANKENY

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James A. Schroder, O.D.
Jesse J. Kahnk, O.D.

Thank you for choosing our practice for your eye care needs. Please complete this form in ink. If you have any questions, do not hesitate to ask for assistance. All information is confidential. (Please print)

PATIENT INFORMATION

Date _____

Nickname _____

First MI Last

Address _____ City _____ State _____ Zip _____

Birthdate _____ Male Female

Primary Language: English Other _____

Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander
 White All Other Races Declined to specify

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined to specify

Please check your preferred phone contact: ___ HOME ___ CELL ___ WORK

Home Phone # _____ Cell Phone # _____ Work Phone # _____

E-mail address _____ Decline

Preferred communication for your next appointment Email Text US Mail

Marital Status: Single Married Widowed Divorced Other

Employer/School _____ Occupation/Student _____ Full Time Part Time

Emergency Contact: _____ Phone # _____ Relationship _____

IF PATIENT IS A MINOR

Mother's name _____ Address _____

Home# _____ Cell# _____ Work# _____ Employer _____

Father's name _____ Address _____

Home# _____ Cell# _____ Work# _____ Employer _____

INSURANCE INFORMATION (Please provide cards upon arrival)

Insurance Company Name _____ Vision coverage: ___ Yes ___ No

Medical coverage: ___ Yes ___ No

Name of primary insured _____ Employer _____

Birth date _____ SSN# _____ Relationship to patient _____

DO YOU HAVE ANY ADDITIONAL INSURANCE?

Insurance Company Name _____ Vision coverage: ___ Yes ___ No

Medical coverage: ___ Yes ___ No

Name of primary insured _____ Employer _____

Birth date _____ SSN# _____ Relationship to patient _____

PLEASE COMPLETE BACK OF THIS PAGE

Health History

Date of last vision exam _____ Name of eye doctor _____

Reason for today's exam _____ Name of medical doctor _____

Do you or anyone in your immediate family have a history of the following? Please use abbreviations to identify self or family member:

S/self **M**/mother **F**/father **B**/brother **SS**/sister **GM**/grandmother **GF**/grandfather **A**/aunt **U**/uncle

____ Cataracts ____ Macular degeneration ____ Glaucoma ____ Blindness ____ Turned or lazy eye

____ Diabetes ____ Heart disease or stroke ____ High blood pressure ____ Thyroid disease ____ Lupus or MS

____ Asthma ____ Lung problems ____ Hay fever ____ Sinus Condition ____ Arthritis

____ Cancer or tumor – Type _____ ____ Skin condition ____ Frequent headaches ____ Hepatitis ____ HIV

List all prescription medications you are currently taking _____

List vitamins or non-prescriptions medications you are currently taking _____

List known drug allergies _____ Other allergies _____

List recent surgeries (past 5 years) _____

Do you have any of the following conditions involving your eyes? Please check all that apply.

____ Eye surgery ____ Eye or head injury ____ Severe pain ____ Eye infection or disease ____ Eye strain

____ Poor near vision ____ Poor distance vision ____ Double vision ____ Light sensitivity ____ Halos ____ Redness

____ Floaters or spots ____ Light flashes ____ Eyes burn, itch, water ____ Discharge from the eye ____ Glare

If you have check any of the above, please explain _____

____ Height Do you: ____ Smoke ____ Consume Alcohol ____ Use recreational drugs

Do you currently wear glasses? ____ Yes ____ No How old are they? _____

Have you ever had difficulty adjusting to new glasses? ____ Yes ____ No Describe briefly: _____

When do you wear your glasses? ____ All the time ____ Reading & near work ____ Distance tasks only ____ Computer ____ Work safety ____ Sports

Do you use a computer or video display terminal? ____ Yes ____ No If yes, how many hours per day? _____

Do you currently have: ____ 2nd pair glasses (for backup or emergency) ____ Sunglasses ____ Sport glasses ____ Work safety glasses

What hobbies or sports do you participate in? _____

Are you interested in trying contact lenses? _____ Do you wear contacts now? _____ Have you ever worn contacts? _____

If so, what style? ____ Soft ____ Gas permeable ____ Colored What cleaning/disinfecting system do you use? _____

How many hours a day do you wear your contacts? _____ How often do you replace your contact lenses? _____

What brand of contacts are you currently wearing? _____ Are you interested in corrective eye surgery? (Lasik/Laser) _____

Authorization

I certify that the above information is accurate and complete to the best of my knowledge. I understand that providing the incorrect information can be dangerous to my health. I authorize the doctor to release any information, including the diagnosis, and the records of any treatment or examination rendered to me or my child during the period of such eye care, to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for my services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

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

_____ Date