Andrew E. Kortz, M.D. Today's Date: ____________________________

How were you referred to us?__________________________ Family Physician: ______________________________

Name: ____**Date of Birth**: ____/____/_____ Age: _____ ◻ Male ◻ Female

SS #: ____________________________ **Marital Status**: ◻ Married ◻ Single ◻ Widowed ◻ Divorced

Address: ___________________________________Apt #: ______City: _________________ State: ____ Zip: ____________

Alternate address: _____________________________ Apt #_____City: ___________________State: ____Zip: ___________

Phone #: (_____) _____________________ Cell #: (_____) _____________________ Alternate #: (_____) ______________

Email: __________________________________ Contact Preference: ◻ Email ◻ Text ◻ Phone

Patient's Employer: ____ Work: (_______)__________________________

Preferred Language: ◻ English ◻ Spanish ◻ Other: _________

Ethnicity: ◻ Hispanic Origin ◻ Non-Hispanic Origin

Race: ◻ White ◻ Black/African American ◻ American Indian/Alaskan Native ◻ Asian ◻ Native Hawaiian/Pacific Islander

Person Responsible (**Guarantor)** ◻ Self

◻ Other: Name: _____________________________Phone # (_____) _________________

Address: ___________________________City _____________St ____Zip_______

Relationship to patient (mother, father, etc…): _____________________________________

Spouse or Parent's Name: ____Date of Birth: ________/_______/_______

Spouse or Parent Employer: ____Phone #: (_____) ____________________

In case of Emergency Notify: ____Phone # (_____) _____________________

1st-Primary Insurance:	**2nd-Secondary:**
Insurance Name:____________________________________	Insurance Name:___________________________________
Insured's Name:____________________________________	Insured's Name:____________________________________
Policy #: ____	Policy #: ____
Group#: ____	Group#: ____
Insured's Date of Birth: _____/_____/_____	Insured's Date of Birth: _____/_____/_____
Insured's SS#: _____________________________________	Insured's SS#: _____________________________________
Relation to Patient: __________________________________	Relation to Patient: _________________________________

Please have ALL INSURANCE CARD(S) AND PHOTO ID ready for photocopying

All Co-pay's and/or co-insurance WILL BE COLLECT at the time of service.

MEDICAL HEALTH HISTORY

Patient Name:______________________________________DOB:____________________Today's Date:________________

LIST OF ALL MEDICATIONS YOU ARE CURRENTLY TAKING:
(Including eye medications)

____
____
____
____

Please use back if additional space is needed. □ See Back

Pharmacy Name: ______________________________________

Pharmacy Street: _______________________zip code: _________

Primary Care doctor: _______________________________M.D.

Who referred you to us: __________________________________

DRUG ALLERGIES: □ **NO known drug allergies**

□**YES** Please list medication allergies/ reactions:___________

____
____
____

LATEX ALLERGIES: □ NO □ YES

When was your **last eye exam**? _______________________

Optometrist's Name: ______________________________

How **OLD** is your current eyeglass prescription?___________

Do you wear **Contact Lens**? □ No □ Yes (how long?)_____

REVIEW OF SYSTEMS

PLEASE ANSWER YES OR NO BELOW and **MARK ANY THAT APPLY**

□**No** □**Yes-CONSTITUTIONAL**: (mark any that apply)
□ Fever □ Weight loss □ Weight Gain
Other:___________________________

□**No** □**Yes-EAR, NOSE, MOUTH &THROAT**
□Sinus Problems □Chronic cough
□Hearing loss/ problems
Other: ___________________________

□**No** □**Yes-CARDIOVASCULAR** (mark any that apply)
□High Blood Pressure
□Heart Attack □Stroke When?__________
□Congestive Heart Failure □Artificial Valve
□Pacemaker
Other: ___________________________

□**No** □**Yes-RESPIRATORY** (mark any that apply)
□Asthma □Emphysema
□Tuberculosis □Lung Cancer
Other: ___________________________

□**No** □**Yes-GASTROINTESTINAL** (mark any that apply)
□Hepatitis/ Jaundice □Reflux
□Ulcers/Bleeding □Pancreatitis
Other: ___________________________

□**No** □**Yes-GENITOURINARY** (mark any that apply)
□Cervical/Uterine/Ovarian Cancer
□Kidney Disease □Prostate Cancer
Other: ___________________________

□**No** □**Yes-INTEGUMENTARY** (mark any that apply)
□Skin Disease:____________
□Skin Allergies?___________
Other: ___________________________

□**No** □**Yes**- Pregnant Nursing ? __Yes __NO

□**No** □**Yes-MUSCULO-SKELETAL** (mark any that apply)
□Degenerative Arthritis
□Rheumatoid Arthritis □Lupus
Other: ___________________________

□**No** □**Yes-NEUROLOGICAL** (mark any that apply)
□Migraines/Headaches
□Alzheimer's □Dementia
□Parkinson's □Epilepsy
Other: ___________________________

□**No** □**Yes-PSYCHIATRIC** (mark any that apply)
□Depression □Schizophrenia
Other: ___________________________

□**No** □**Yes-HEMATOLOGIC/LYMPHATIC**
□Anemia □Bleeding Disorder
□Sickle Cell Disease □Leukemia
Other: ___________________________

□**No** □**Yes-IMMUNOLOGIC** (mark any that apply)
□Hepatitis A, B or C
□HIV/AIDS
Other: ___________________________

□**No** □**Yes-ENDOCRINE** (mark any that apply)
□Diabetes——How Long?____________
□Thyroid Disorders
Other: ___________________________

□**No** □**Yes– Have you had Cancer, if yes please describe**

Type: ___________________________

Is there any other condition, medication or information not included above? If so please describe:__________________
____

PLEASE CONTINUE ON NEXT PAGE

PAST, FAMILY MEDICAL HISTORY

- **PAST OCULAR HISTORY** **□None**

  Have you ever been diagnosed with:
  □Cataracts □Glaucoma □Cornea Disease
  □Macular Degeneration □Diabetic Retinopathy
  □Retinal Problems □Eye Muscle
  □Eye Injury/trauma__________________
  □Other: ______________________________________

- **PAST OCULAR SURGERY** **□None**

  Please list any eye procedure/surgeries: (Cataract surgery, laser surgery, retina surgery, or refractive surgery)
  Date and Type:
  ____
  ____

- **PAST MEDICAL/ SURGICAL HISTORY** **□None**

  List previous surgeries or major illnesses: (Date and Type)
  ____
  ____

- **FAMILY HISTORY** **□ None**

  List any **major illnesses/hereditary problems** of parents, brothers/sisters and/or grandparents:
  ____
  ____

- **FAMILY OCULAR HISTORY** **□ None**

  (parents, siblings, grandparents)
  □Cataracts __________________________________
  □Glaucoma__________________________________
  □Cornea Disease______________________________
  □Macular Degeneration________________________
  □Diabetic Retinopathy_________________________
  ____
  ____

- **SOCIAL HISTORY**

Do you Smoke? Yes or No ____packs a day _____# years
Quit Date:_____________________________
Do you use Alcohol? Yes or No ______# drinks a day
Quit Date: _____________________________
Do you use Recreational Drugs? Yes or No How often_____

Current/Previous Occupation:_______________________________

Why are we seeing you TODAY? Please be specific.
____
____
____
____

- **CURRENT OCULAR HISTORY**

Are you presently having any of the following problems:

□Blurry vision
□Burning
□Distorted vision
□Double vision
□Dryness
□Excess tearing/watery
□Foreign body sensation
□Glare/light sensitivity
□Itching
□Loss of Vision
□Discharge
□Redness
□Sandy or gritty feeling
□Stye/chalazion
□Other: ____
□ **NONE**

- **Are you having any difficulty with the following:**
  (Mark all that apply)

□Reading small print (newspaper, medicine labels, food labels)
□Recognizing people when close
□Glare while driving at night or bright lights
□Reading street/traffic signs up close or at a distance
□Writing (checks, cards, etc..)
□Playing games/sports (cards, golf, etc..)
□Watching TV/Movies
□Other: ____
□ **NONE**

- **Are you satisfied with your present vision?**
  □ No **□Yes**

X ____ Date:___________________________
Patient Signature

Andrew E. Kortz, M.D.

SIGNATURE ON FILE/BILLING/HIPAA SUMMARY

Complete and sign the appropriate method of payment.
If we are filing an insurance claim for you, please bring your card(s) to your appointment.

This document is a condensed version of our HIPAA Policy Statement and financial agreement. Our detailed policy/billing statement and Notice of Privacy Practices is available in our office. We would be happy to provide you with a copy upon your request.

The key items of our insurance/billing policy are:
It is the **RESPONSIBILTY OF THE PATIENT** to know when you need a referral, pre-certification or second opinion. We will file your insurance for you if you have a medical diagnosis (determination of a glasses prescription is a non-covered service)

BY SIGNING BELOW, YOU ARE ACKNOWLEDGING:

***you were informed of these forms** *** your right to receive a copy of them** ***your agreement to the policy**

SELF		**SELF-PAY:** I understand payment is my responsibility due to no insurance or other reasons. I will pay with ☐ CASH ☐ CHECK ☐ CREDIT CARD X____________________________________ __________ SIGNATURE DATE
INSURANCE		**AUTHORIZATION:** I authorize Dr. Kortz to release any information in the course of my examination or treatment to my insurance company and permit payment be made directly to him any benefits due for this service. **I accept personal responsibility for any balance or fee not covered**. If the insurance company pays me directly for services rendered, I will immediately forward that payment to Dr. Kortz. X____________________________________ __________ SIGNATURE DATE
MEDICARE		**MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to **Andrew Kortz, M.D.**, for services furnished me by **Andrew Kortz, M.D.** I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and it agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on the approved claims forms, my signature authorized releasing the information to the insurer or agency shown. **Andrew Kortz, M.D** accepts the charge determination of the Medicare carrier as the full charge, and **I am responsible only for the deductible, coinsurance and noncovered services. Coinsurances and deductible are based upon the charge determination of the Medicare Carrier.**
HIPAA		**By signing below. you acknowledge that you were informed of our Notice of Privacy Practices and of your right to receive a copy of it.** ____________________________________ PATIENT NAME PRINTED X____________________________________ __________ SIGNATURE DATE