Tara Hake, OD
Tyler Kennedy, OD
Kristina Kennedy, OD

PATIENT INFORMATION

Name (First Middle Last): _____ **Name Preferred:** _____

Date of Birth: _____ **Sex:** Male Female **Social Security #:** _____

Address: _____ **City/State/Zip:** _____

Phone (Home/Cell/Work): _____

Email: _____ **Preferred Contact:** ☐Home ☐Cell ☐Work ☐Email

Marital Status: _____ **Spouse's Name:** _____

Employer: _____ **Occupation:** _____ **Phone:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Race ☐American Indian or Alaskan Native ☐Asian ☐Black or African American
☐Native Hawaiian or Pacific Islander ☐White or Caucasian ☐Prefer to not answer

Ethnicity ☐Hispanic or Latino ☐Not Hispanic or Latino

Primary Care Provider: _____

Preferred Pharmacy: _____

How did you hear about our practice: _____

To Be completed for Minor Patient's ONLY:

Fathers Name: _____

Date of Birth: _____ **Social Security #:** _____

Address: _____ **City/State/Zip:** _____

Phone: _____ **Email:** _____

Employer: _____ **Occupation:** _____

Mothers Name: _____

Date of Birth: _____ **Social Security #:** _____

Address: _____ **City/State/Zip:** _____

Phone: _____ **Email:** _____

Employer: _____ **Occupation:** _____

MANHATTAN EYECARE

Insurance Information*

Primary Insurance:_____ **Policy Holder's Name:** _____

Date of Birth: _____ **Social Security #**:** _____

Secondary Insurance:_____ **Policy Holder's Name:** _____

Date of Birth: _____ **Social Security #**:** _____

*Please present medical and vision insurance upon check in. There are times that the doctor may make a medical diagnosis and it will be charged accordingly.
**We obtain your SS# for the purpose of filing insurance.

Insurance Agreement

I hereby authorize payment of insurance benefits to Dr. Tara Hake, Dr. Tyler Kennedy and Dr. Kristina Kennedy, OD DBA Manhattan Eye Care, LLC for covered services and fees. I authorize them to release to my insurance carrier any information necessary to process claims. A scanned/photocopy of this authorization will be considered as valid and the original. I understand that I am responsible for payment of all charges not covered by insurance or 60 days pasts due.

Signature: _____ **Date:** _____

Financial Agreement

I understand that I am responsible for payment of my co-pay or any outstanding balance at the time of my appointment. If I purchase glasses or contacts, I understand that I am responsible for full payment at time of order. If I am unable to provide full payment at time of order, a payment arrangement may be set up so that full balance is received prior to picking up my glasses or contacts. I understand that if I do not present my insurance at the time of service, I may be responsible for full payment and the claim may not be able to be filed with my insurance company.

Signature: _____ **Date:** _____

Acknowledgement of HIPAA Privacy Notice

I have received a copy of Notice of Privacy Practices dated xx/xx/xxxx as required by HIPAA Privacy Regulations.

Signature: _____ **Date:** _____

Manhattan Eye Care may release HIPAA related information to (Please include name and type of information we may release to them, if not ALL information):

_____

Permission for Dilation

Pupil dilation is an important part of a comprehensive eye exam and is offered at no additional charge. The most common side effects are increased sensitivity to light and reduction of near focusing ability. Some patients may experience difficulty in driving and may wish to schedule the dilation when they have a driver. The effects usually last 2-4 hours. A dilated pupil allows a more thorough view of the structures inside the eye which allows the doctor to detect otherwise undiagnosed cataracts, glaucoma, diabetic retinopathy, macular degeneration, retinal detachments and other serious conditions.

_____ Yes I do give permission for the diagnostic drops to be instilled in my eyes for the purpose of dilation

_____ No I do not give permission for the diagnostic drops to be instilled in my eyes for the purpose of dilation

Signature: _____ **Date:** _____

MANHATTAN EYECARE

Patient Medical History

Name (First Middle Last): _____ **Date of Birth:** _____

Please indicate if you have been diagnosed with any of the following medical conditions.

Allergic/Immunologic	**Psychiatric**	**Neurological**
Drug Allergy	Depression	Multiple Sclerosis
Please list what drug	Panic Disorder	Epilepsy
	Schizophrenia	Alzheimers
Environmental Allergy	**Hematologic / Lymphatic**	Parkinsons
Please list allergen	Anemia	Cerebrovascular
	Large Volume Blood Loss	**Constitutional**
Rheumatoid Arthritis	Leukemia	Developmental Disability
Lupus	**Endocrine**	Weight Loss
Eyes	Non-Insulin Diabetes	Fever
Glaucoma	Insulin Diabetes	Fatigue
Cataract	Thyroid Dysfunction	Trauma
Macular Degeneration	Hormone Dysfunction	**Ear, Nose, Mouth & Throat**
Surgery	**Cardiovascular**	Upper Respiratory Tract Infection
Dry Eye	Heart Disease	Ear Ache
Blurred Vision	Hypertension	Runny Nose
Double Vision	Stroke	Sore Throat
Blindness	Vascular Disease	Ringing
Lazy Eye	**Gastrointestinal**	**Respiratory**
Musculoskeletal	Crohn's	Asthma
Fibromyalgia	Colitis	Bronchitis
Muscle Dystrophy	Ulcer	Emphysema
Osteoarthritis	Digestive	**Integumentary**
Ankylosing Spondylitis		Eczema
Genitourinary		Rosacea
STD, Viral Herpetic, Chlamydia		Psoriasis

Please list any other medical conditions not included in table that you have been diagnosed with:

_____

List any medications that you are currently taking (include over the counter, vitamins, supplements etc.):

_____

Patient Social History

Tobacco Use: Current - How many per day_____ Occasional Former Never

Alcohol Use: Yes - How many per week_____ Occasional Former Never

What hobbies do you enjoy?

_____

Are you currently experiencing any specific vision problems?

_____

Do you wear glasses?_____ **If yes, how old are they?** _____

Do you wear contacts?_____ **If so, how old are they?** _____