

108 NE 2nd Rd
 Concordia, MO 64020
 (660) 463-7915

INSIGHT EYECARE
 602 N Maguire St
 Warrensburg, MO 64093
 (660) 747-7300

217 S College St
 Richmond, MO 64085
 (816) 776-2900

Patient Last, First MI		Nickname	Sex M F	DOB	State of Birth
Street		Please checkmark below Communication preference		SS#	
City		<input type="checkbox"/> Home		Race <input type="checkbox"/> American Indian/Alaska <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Patient Declined Ethnicity <input type="checkbox"/> Non Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Patient Declined Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____	
State, Zip		<input type="checkbox"/> Work / Ext.			
Country <small>United states</small> Type <input type="checkbox"/> Home <input type="checkbox"/> Mailing		<input type="checkbox"/> Cell / Carrier			
Mothers Maiden Name		<input type="checkbox"/> Email			
Account Responsible Last, First MI		DOB	SS#		
Relationship to Patient		Work Phone #	Home Phone#		
Employer	Occupation				

Do you have medical insurance through this Employer? Yes No If yes, list as primary below.
 Do you have medical insurance through your spouse's employer? Yes No
 Do you have Medicare? Yes No Do you have Medicare supplement? Yes No If yes, list as secondary below.
 Do you have Medicaid? Yes No

Name of policyholder <input type="checkbox"/> Check for Patient	Patient's relationship to policyholder	DOB of policyholder	SS # of policyholder
Primary Insurance Name		ID #	Group #
Name of policyholder <input type="checkbox"/> Check for Patient	Patient's relationship to policyholder	DOB of policyholder	SS # of policyholder
Secondary Insurance Name		ID #	Group #
Name of policyholder <input type="checkbox"/> Check for Patient	Patient's relationship to policyholder	DOB of policyholder	SS # of policyholder
Additional Insurance Name		ID #	Group #

Who may we thank for referring you to our office:

<input type="checkbox"/> Family/Friend _____	<input type="checkbox"/> Internet	<input type="checkbox"/> Insurance List
<input type="checkbox"/> Doctor Referral	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Saw Sign/Building

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVATE PRACTICE

I acknowledge that I have received a copy of InSight Eyecare's Notice of Privacy Practices.

Patient Signature _____ **Date** _____

Patient Signature _____ **Date** _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ **Print Name:** _____

My personal health information may be released to: _____

MEDICATIONS			ALLERGIES	
NAME:	DOSE:	QTY:	ALLERGY	REACTION
NAME:	DOSE:	QTY:		
NAME:	DOSE:	QTY:		
NAME:	DOSE:	QTY:		
NAME:	DOSE:	QTY:		
NAME:	DOSE:	QTY:		
NAME:	DOSE:	QTY:		
NAME:	DOSE:	QTY:		

SURGICAL HISTORY		
Procedure/Date _____ / _____	Procedure/Date _____ / _____	Procedure/Date _____ / _____

EYE HEALTH HISTORY						
Condition	Self	Family/ Relationship	Condition	Self	Family/Relationship	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/> _____	Amblyopia	<input type="checkbox"/>	<input type="checkbox"/> _____	
Cataracts	<input type="checkbox"/>	<input type="checkbox"/> _____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/> _____	
ARMD	<input type="checkbox"/>	<input type="checkbox"/> _____	Cancer	<input type="checkbox"/>	<input type="checkbox"/> _____	
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/> _____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/> _____	
Retinal disease	<input type="checkbox"/>	<input type="checkbox"/> _____	Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/> _____	
Other Disease	<input type="checkbox"/>	<input type="checkbox"/> _____	Glasses	<input type="checkbox"/>	<input type="checkbox"/> _____	
Blindness	<input type="checkbox"/>	<input type="checkbox"/> _____	Contact lenses	<input type="checkbox"/>	<input type="checkbox"/> _____	
Strabismus	<input type="checkbox"/>	<input type="checkbox"/> _____				

HEALTH HISTORY		
<p>CONSTITUTIONAL (general issues)</p> <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight-Sudden Gain <input type="checkbox"/> Weight-Sudden Loss <input type="checkbox"/> Other _____ <p>VASCULAR/CARDIOVASCULAR</p> <input type="checkbox"/> Bypass Surgery <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Stroke <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Other _____ <p>EARS, NOSE, MOUTH, THROAT</p> <input type="checkbox"/> Ear Infections <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Sinusitis <input type="checkbox"/> Chronic Cold <input type="checkbox"/> Other _____ <p>RESPIRATORY</p> <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Lung Cancer <input type="checkbox"/> COPD <input type="checkbox"/> Other _____ <p>GASTROINTESTINAL</p> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn <input type="checkbox"/> Ulcers <input type="checkbox"/> Other _____	<p>GENITOURINARY (genitals/kidney/bladder)</p> <input type="checkbox"/> Bladder Cancer <input type="checkbox"/> Dialysis <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Ovarian Cysts <input type="checkbox"/> Other _____ <p>BONES/JOINTS/MUSCLES</p> <input type="checkbox"/> Pain-Joint / Back / Muscle <input type="checkbox"/> Arthritis <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Scoliosis <input type="checkbox"/> Other _____ <p>INTEGUMENTARY</p> <input type="checkbox"/> Eczema <input type="checkbox"/> Melanoma <input type="checkbox"/> Skin Cancer <input type="checkbox"/> Ulcers <input type="checkbox"/> Other _____ <p>NEUROLOGICAL</p> <input type="checkbox"/> Bell's Palsy <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Dementia <input type="checkbox"/> Epilepsy <input type="checkbox"/> Migraines <input type="checkbox"/> Other _____	<p>PSYCHIATRIC</p> <input type="checkbox"/> Mood Swings <input type="checkbox"/> Depression <input type="checkbox"/> Autism <input type="checkbox"/> Mentally Handicapped <input type="checkbox"/> ADHD <input type="checkbox"/> Other _____ <p>ENDOCRINE</p> <input type="checkbox"/> Diabetes - Type ____ <input type="checkbox"/> Thyroid Cancer <input type="checkbox"/> Thyroidectomy <input type="checkbox"/> Other _____ <p>HEMATOLOGIC/LYMPHATIC</p> <input type="checkbox"/> Anemia <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Blood clots <input type="checkbox"/> Other _____ <p>ALERGIC/IMMUNOLOGIC</p> <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Leukemia <input type="checkbox"/> Lupus <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Other _____