

# EyeCare Consultants, LLP

*Medical/Surgical EyeCare Specialists*  
By Referral Only

101 N. W. First Street, Suite 112  
Old Post Office Place  
Evansville, Indiana 47708-1259  
Telephone (812) 426-2020  
Fax (812) 426-2828

**Matthew M. Boyer, M.D.**     **William G. Carey, M.D.**  
**Walter H. Egenmaier, O.D.**     **Stephan A. VanCleve, O.D.**

Welcome to EyeCare Consultants,

At the request of your doctor, we have scheduled an appointment for you on \_\_\_\_\_ . We have set aside approximately 1 1/2 to 3 hours for your first appointment so we may do a complete and thorough exam.

Please take a few moments and completely fill out the attached forms. If your appointment is scheduled within 2 days, please bring these to the office with you. If your appointment is scheduled further off, please mail these back to us. These forms will assist us in providing you the best possible care. Please bring a list of all medications you are currently taking, their dosages and any medications that you may be allergic to.

Please bring your Driver's License, or Picture ID, and all of your Health Insurance Cards so that we may assist you in filing your health insurance claim for services rendered. Please contact your health insurance company for any questions regarding your benefits for medical care. It is our policy to collect all co-pays, co-insurance, and deductibles at the time of service. If you do not have insurance or we do not have a contractual agreement with your insurance company, we will collect payment in full at time of service unless prior arrangements have been made. We accept Cash, Check, Visa, MasterCard, and Discover.

Due to Indiana Law, if you have a legal Power of Attorney who makes your medical decisions, we are required to obtain their consent to treat you and bill your insurance. Please make sure your Power of Attorney is either with you or that we are able to reach them by phone prior to your appointment. Also, if possible, bring a copy of the legal documents so that we may keep documentation in your medical record.

Due to new government regulation, we must inform you, that our physicians have partial ownership in the EyeCare Consultants Surgery Center. You will be given a form the day of your appointment entitled "Patient's Rights and Notification of Physicians Ownership" to sign.

If you are unable to keep your scheduled appointment, please call our office to cancel your appointment at least 24 hours in advance if possible.

Thank you for choosing EyeCare Consultants. We look forward to assisting you with your eye care needs.

Our office is located in the Old Post Office Place; we are on the ground floor of the red brick building beside a breezeway. Please park in the courtyard between the Old Post Office and Old Post Office Place.

**From Henderson:**

Take **US 41 N**. Take **I-164 E** exit towards **Veterans Memorial Parkway**. Veterans Memorial Parkway will turn into **S E Riverside Drive** as you reach downtown Evansville. Turn **Right** on **Vine Street**. Go 1 1/2 blocks. Take right immediately after red brick building into "**Old Post Office Place Parking**".

**From Mt. Vernon:**

Take **Lloyd Expressway East** to the **Fulton Ave** exit. Turn **Right** onto **Fulton Avenue**. Turn **Left** onto **Second Street**. Go three to four blocks to **Vine Street** and then take a **Right** on **Vine Street**. Go 1/2 block up and turn **Left** immediately in front of the Red brick Building into "**Old Post Office Place Parking**".

**From Newburgh:**

Take **Lloyd Expressway West** to the **First Ave / Martin Luther King Jr. Boulevard** exit. Turn **Left** onto **Martin Luther King Jr. Boulevard**. Go two blocks up and turn **Right** on **Vine Street**. Staying in right lane, you will go approximately 5-6 blocks until you get to **Second Street**. Proceed **THRU Second Street**. Turn **Left** immediately in front of the Red brick Building into "**Old Post Office Place Parking**".

**From Princeton:**

Take **US 41 S** to the **Lloyd Expressway West** exit. Then take the **First Avenue / Martin Luther King Jr. Boulevard**. Turn **Left** onto **Martin Luther King Jr. Boulevard**. Go two blocks up and turn **Right** on **Vine Street**. Staying in right lane, you will go approximately 5-6 blocks until you get to **Second Street**. Proceed **THRU Second Street**. Turn **Left** immediately in front of the red brick Building into "**Old Post Office Place Parking**".

# EyeCare Consultants PATIENT INFORMATION SHEET

## PATIENT INFORMATION

Last Name:		First Name:					M.I.		
Social Security #:	Date of Birth:	Marital Status:	S	M	W	D	SEP	Male	Female
Street Address:			City:			State:		Zip:	
Home Phone: ( )	Work Phone: ( )	Ext:		Cell Phone: ( )					
Employer:	Occupation:	The number we can call during the day: ( )							
Employer Address:			City:			State:		Zip:	

## INSURANCE HOLDER INFORMATION

Last Name:		First Name:					M.I.		
Social Security #:	Date of Birth:	Marital Status:	S	M	W	D	SEP	Male	Female
Street Address:			City:			State:		Zip:	
Home Phone: ( )	Work Phone: ( )	Ext:		Cell Phone: ( )					
Employer:	Occupation:	The number we can call during the day: ( )							
Employer Address:			City:			State:		Zip:	
Relationship to Patient:									

## SPOUSE or PARENT or RESPONSIBLE PARTY INFORMATION

Last Name:		First Name:					M.I.		
Social Security #:	Date of Birth:	Marital Status:	S	M	W	D	Sep	Male	Female
Street Address:			City:			State:		Zip:	
Home Phone: ( )	Work Phone: ( )	Ext:		Cell Phone: ( )					
Employer:	Occupation:	The number we can call during the day: ( )							
Employer Address:			City:			State:		Zip:	
Relationship to Patient:									

## PERSON TO CONTACT IN CASE OF AN EMERGENCY (OTHER than Spouse)

Last Name:		First Name:					M.I.		
Home Phone: ( )	Work Phone: ( )	Ext:		Cell Phone: ( )					
Relationship to Patient:									

## DOCTOR INFORMATION

Optometrist:	Family Doctor:
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## SECURITY QUESTION (Please choose ONE from the following)

1. What is your Mother's Maiden Name?
2. What is the Name of the City where you were Born?
3. What is the name of the High School you attended?
4. What is the Name of your Favorite Pet?

**EyeCare Consultants  
PATIENT INFORMATION SHEET (Continued)**

**INSURANCE INFORMATION**

<b>Name of Primary Insurance:</b>				
<b>Name of Subscriber:</b>		<b>Name of Subscriber's Employer:</b>		
<b>Relationship to Patient:</b>	Self	Spouse	Child	Other:
<b>Name of Secondary Insurance:</b>				
<b>Name of Subscriber:</b>		<b>Name of Subscriber's Employer:</b>		
<b>Relationship to Patient:</b>	Self	Spouse	Child	Other:
<b>Name of Other Insurance:</b>				
<b>Name of Subscriber:</b>		<b>Name of Subscriber's Employer:</b>		
<b>Relationship to Patient:</b>	Self	Spouse	Child	Other:

**NOTICE OF PRIVACY PRACTICES**

By signing below, I acknowledge that I have received the Notice of Privacy Practices form from EyeCare Consultants, LLC.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

TODAY'S DATE: \_\_\_\_\_ CHART ID: \_\_\_\_\_

NAME: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ RACE: \_\_\_\_\_

Referring Dr: \_\_\_\_\_

Primary Care Dr: \_\_\_\_\_

List any surgeries you have had (Cataract, Tonsils, Appendix, etc.): \_\_\_\_\_

Are you a new patient? Y or N (Please circle response)

Tech: \_\_\_\_\_

If "No", has your medical history changed since your last visit? Y or N ? Date of last eye exam: \_\_\_\_\_

Dr: \_\_\_\_\_

1. EYES: (Circle ALL That Apply)

Is this Workman's Comp? Y or N

Vision Loss

Mucous Discharge

Excess Tears / Watering

Blurred Vision

Watery Discharge

Light Sensitivity

Fluctuating Vision

Redness

Eye Pain or Soreness

Distorted Vision

Sandy / Gritty Feeling

Lazy or Crossed Eyes

Loss of Side Vision

Itching

Eye or Lid Infection

Double Vision

Burning

Tired Eyes

Dryness

Foreign Body Sensation

Drooping Eyelids

PAST OCULAR HISTORY:

(Circle ALL That Apply)

Cataract

Trauma

Glaucoma

Macular Degeneration

Lazy Eye

Diabetic Retinal Changes

Brief description of your eye problem, when it began, and if it is getting worse, better, or fluctuates: \_\_\_\_\_

Do you currently have any problems in the following areas?  
If "Yes", Please provide information.

FAMILY HISTORY:

Does anyone in your immediate family have any of the following?  
(Circle all that apply and list family member)

Blindness

High Blood Pressure

Glaucoma

Kidney Disease

Arthritis

Lupus

Cancer

Stroke

Diabetes

Thyroid Disease

Heart Disease

Other: \_\_\_\_\_

Explanation of Problem: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. General (Fever, Weight Loss, etc.)
3. Ear, Nose, Throat (Sinus, Dry Mouth, etc.)
4. Cardiovascular (Heart, Stroke, Blood Pressure, etc.)
5. Respiratory (Asthma, Bronchitis, etc.)
6. Gastrointestinal (Stomach Ulcers, etc.)
7. Genital, Kidneys, Bladder (Prostate, etc.)
8. Muscles, Bones, Joints (Arthritis, etc.)
9. Skin (Warts, Acne, Cancer, etc.)
10. Neurological (Multiple Sclerosis, Tumor, etc.)
11. Psychiatric (Anxiety, Depression, Insomnia, etc.)
12. Endocrine (Diabetes, Thyroid Dysfunction, etc.)
13. Blood / Lymph (High Cholesterol, Anemia, etc.)
14. Allergic / Immunologic (Hay Fever, Lupus, etc.)

Explanation of Problem: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SOCIAL HISTORY:

Are You:      Single              Married              Widowed              Divorced

                    Employed              Retired              Other: \_\_\_\_\_

Occupation: \_\_\_\_\_

Do You:    Smoke or use tobacco products?      Y or N

Packs per day or week? \_\_\_\_\_

Drink alcohol?      Y or N

Drinks per day or week? \_\_\_\_\_

List Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List Eye Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List Allergic Reaction to Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**EyeCare Consultants**  
**VISUAL DISABILITY INVENTORY**

NAME (Please Print): \_\_\_\_\_ DATE: \_\_\_\_\_ CHART ID: \_\_\_\_\_

PLEASE REVIEW THE FOLLOWING QUESTIONS AND CIRCLE ALL THAT APPLY

1. MY VISION DECREASES MY QUALITY OF LIFE THEREFORE I NEED IMPROVED EYESIGHT. Y N

2. READING IMPAIRMENT:

A Are you able to read the newspaper? <span style="float: right;">Y N</span>	E Do you frequently need a magnifier? <span style="float: right;">Y N</span>
B Are you able to read the mail? <span style="float: right;">Y N</span>	F Are you having difficulty seeing to write checks or pay bills? <span style="float: right;">Y N</span>
C Are you able to read the Bible? <span style="float: right;">Y N</span>	G Do you need plenty of light to read? <span style="float: right;">Y N</span>
D Are you able to read medicine bottles? <span style="float: right;">Y N</span>	

3. HOUSEHOLD ACTIVITIES:

A While cooking are you able to see the stove, knobs, labels and/or recipes? <span style="float: right;">Y N</span>	H Do you have difficulty cleaning house? <span style="float: right;">Y N</span>
B Are you having difficulty climbing stairs and/or holding on to the banister? <span style="float: right;">Y N</span>	I Do you have difficulty performing yard work? <span style="float: right;">Y N</span>
C Are you having difficulty walking and/or unable to see uneven pavement? <span style="float: right;">Y N</span>	J Do you have difficulty caring for your family? <span style="float: right;">Y N</span>
D Do you have frequent falls? <span style="float: right;">Y N</span>	K Do you have difficulty getting to the doctor? <span style="float: right;">Y N</span>
E Do you have difficulty shaving? <span style="float: right;">Y N</span>	L Do you have difficulty shopping? <span style="float: right;">Y N</span>
F Do you have difficulty bathing? <span style="float: right;">Y N</span>	M Do you live alone? <span style="float: right;">Y N</span>
G Do you have difficulty washing dishes? <span style="float: right;">Y N</span>	

4. DRIVING:

A Daytime: Are you bothered by the sun's glare? <span style="float: right;">Y N</span>	D Do you have difficulty with depth perception? <span style="float: right;">Y N</span>
B Nighttime: Are you bothered by headlights from oncoming cars? <span style="float: right;">Y N</span>	E Do you have difficulty seeing the driveway? <span style="float: right;">Y N</span>
C Dusk: Is it difficult to discern details? <span style="float: right;">Y N</span>	

5. RECOGNITION:

Are you able to recognize people? Y N

6. HOBBIES:

A Do you sew? <span style="float: right;">Y N</span>	E Are you active in sports? <span style="float: right;">Y N</span>
B Do you collect stamps? <span style="float: right;">Y N</span>	F Do you do your own lawn care? <span style="float: right;">Y N</span>
C Do you garden? <span style="float: right;">Y N</span>	G Do you watch a lot of TV? <span style="float: right;">Y N</span>
D Do you collect coins? <span style="float: right;">Y N</span>	
F Do you participate in any other hobbies or recreation? _____	

7. EMPLOYMENT:

A Are you able to perform your job? <span style="float: right;">Y N</span>	
B Are you at risk for injury at your job? <span style="float: right;">Y N</span>	
C Can you drive to work? <span style="float: right;">Y N</span>	
D If YES to any of the above, please describe your occupation: _____	

8. DOUBLE VISION:

Do you ever see double? Y N

9. DIFFERENT IMAGE SIZES:

Do items look the same size to you regardless of which eye your looking out of? Y N

SIGNATURE: \_\_\_\_\_

## EyeCare Consultants PATIENT MEDICATION LIST

<b>Patient Name:</b>		<b>DOB:</b>		<b>Date:</b>
Current Medications that you take. Please INCLUDE all over-the-counter medications, Herbals, & Vitamins.	What is the Dosage for this medicine?	How do you take this medicine?	How often do you take this medicine?	What is this medicine prescribed for?
Example	20 mg	Once, Twice, As Needed, Etc...	AM, PM	Diabetes, Heart, Depression, Etc...
Allergies:	Reactions:	Allergies:	Reactions:	

Latex Allergy?    Yes    No      Your Reaction to Latex if Allergic: