EyeCare **Consultants, LLP**

Medical/Surgical EyeCare Specialists
By Referral Only

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Old Post Office Place
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Matthew M. Boyer, M.D. **Christopher Ambrose, O.D.**
Walter H. Egenmaier, 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:

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

Name of Primary Insurance:				
Name of Subscriber:			**Name of Subscriber's Employer:**	
Relationship to Patient:	**Self**	**Spouse**	**Child**	**Other:**

Name of Secondary Insurance:				
Name of Subscriber:			**Name of Subscriber's Employer:**	
Relationship to Patient:	**Self**	**Spouse**	**Child**	**Other:**

Name of Other Insurance:				
Name of Subscriber:			**Name of Subscriber's Employer:**	
Relationship to Patient:	**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.

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: _____

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: _____

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 QUAILITY OF LIFE THEREFORE I NEED IMPROVED EYESIGHT. Y N

2. READING IMPAIRMENT:

- **A** Are you able to read the newspaper? Y N
- **B** Are you able to read the mail? Y N
- **C** Are you able to read the Bible? Y N
- **D** Are you able to read medicine bottles? Y N
- **E** Do you frequently need a magnifier? Y N
- **F.** Are you having difficulty seeing to write checks or pay bills? Y N
- **G** Do you need plenty of light to read? Y N

3. HOUSEHOLD ACTIVITIES:

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

4. DRIVING:

- **A** Daytime: Are you bothered by the sun's glare? Y N
- **B** Nighttime: Are you bothered by headlights from oncoming cars? Y N
- **C** Dusk: Is it difficult to discern details? Y N
- **D** Do you have difficulty with depth perception? Y N
- **E** Do you have difficulty seeing the driveway? Y N

5. RECOGNITION:

Are you able to recognize people? Y N

6. HOBBIES:

- **A** Do you sew? Y N
- **B** Do you collect stamps? Y N
- **C** Do you garden? Y N
- **D** Do you collect coins? Y N
- **E** Are you active in sports? Y N
- **F.** Do you do your own lawn care? Y N
- **G** Do you watch a lot of TV? Y N

F. Do you participate in any other hobbies or recreation? _____

7. EMPLOYMENT:

- **A** Are you able to perform your job? Y N
- **B** Are you at risk for injury at your job? Y N
- **C** Can you drive to work? Y N
- **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

Patient Name: **DOB:** **Date:**

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:**