Gleason-Janky Eye Physicians

611 N Diers Ave. Ste 2, Grand Island, NE 68803
Phone (308) 381-4733 Fax (308) 381-6462

Patient's Name: ______________________ **Home Phone**: ______________

Street Address: ______________________ **Cell Phone:** ______________

Mailing Address: ______________________

City, State, Zip Code: ______________________

Email: ______________________

Age: ________ **Birth Date:** ________ **Patient SS#** ______________ **Sex (circle) M F**

Marital Status: Single Married Widowed Divorced Other

Primary Language: ______________________

Race: ______________________

Ethnicity: ______________________

Employer: ______________________ **Pharmacy:** ______________________

General Medical Doctor: ______________________ **Date of last exam:** ______________

Eye Doctor: ______________________ **Date of last exam:** ______________

Emergency Contact Name: ______________________ **Phone:** ______________

Emergency Contact Relation:______________________

Primary Insurance: ______________________ **Secondary Insurance**: ______________________

Policy Holder's Name, Date of Birth, and SSN:______________________

If Patient is a Child <u>18</u> years or younger, list Parent's Name: ______________________

Review of Systems: **CIRCLE** medical conditions/surgeries that you have had in the past **or** are currently being treated for:

Cardiovascular
Arrhythmia/A-Fib.
Bypass Surgery/Stent
Congestive Heart Failure
Heart Attack
High Blood Pressure
Pacemaker
Valve Replacement

Ear, Nose, Throat
Hearing Loss/Aids
Meniere's Disease
Sinus Surgery
Vertigo

Respiratory
Asthma
COPD
Lung Cancer
Sleep Apnea/CPAP
Tuberculosis

Gastrointestinal
Colon Cancer
Chrohn's Disease
Hepatitis A/B/C
Ulcerative Colitis

Genitourinary
Breast Cancer
Prostate Cancer
Dialysis/Kidney Failure

Musculoskeletal
Back Surgery
Neck Surgery
Hip Replacement
Knee Replacement

Skin
Eczema
Rosacea
Skin Cancer
-Basal/Squamous Cell
-Melanoma

Neurological
Alzheimers/Dementia
Autism
Bells Palsy
Epilepsy/Seizures
Migraines
Multiple Sclerosis
Paralysis
Stroke/TIA

Psychiatric
Anxiety
Depression
Panic Attacks

Endocrine
Diabetes -insulin
Diabetes- non-insulin
Hyperthyroidism/Graves
Hypothyroidism
Thyroid Cancer

Hematologic
Anemia
Leukemia
Lymphoma
Lyme Disease

Immunologic
COVID
HIV
Lupus
Rheumatoid Arthritis
Shingles

Allergies
Seasonal/Hay fever

History of
Chemotherapy
Radiation therapy

Other Diagnosis/Surgeries

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Social History
Smoker- Yes/ No/ Quit

Patient Eye History: **CIRCLE** any eye conditions that you have had in the **past** or are **currently** being treated for:

Glaucoma
Glaucoma
Glaucoma suspect

Cataract
Cataracts
Cataract Surgery R /L /Both

Macular Degeneration
Dry Macular Degeneration
Wet Macular Degeneration
Previous/Current Injections

Retinal Disease
Retinal Detachment/Tear
Retinal Surgery
Artery/Vein Occlusion
Epiretinal Membrane

Eye Injury
Eye trauma
Foreign Body Removal

Cornea
Corneal Transplant/DSEK
Keratoconus
Pterygium

Strabismus (Turned Eye)
Eye turning In/Out
Muscle Surgery

Amblyopia (Weak Eye)
Right eye/ Left Eye
History of Patching
History of Cyclo drops

Dry Eyes
Using Artificial tears
Using Restasis/ Xiidra/ Cequa
Poor Eyelid Closure
Sjogrens Syndrome

Refractive
Glasses/ Contact Lenses
Reading glasses-Over the counter
Refractive Surgery-LASIK/LASEK/RK

Eyelid Surgery
Blepharoplasty/Ptosis Repair

Eye complications from Diabetes
Injections / Laser
Retinopathy

Other
Iritis

Family History: **CIRCLE** any that apply to immediate relatives:

Cataracts
Glaucoma
Macular Degeneration
Retinal Disease
Eye turning/weak eye
Diabetes

Patient Consent and Release:

I understand that even if Gleason Janky Eye Physicians is contracted with my health care plan, I am ultimately responsible for payment of both covered and non-covered services performed during the course of my treatment. I request payment of authorized benefits by my insurance plan be made on my behalf to Gleason Janky Eye Physicians for services rendered and request that Gleason Janky Eye Physicians submit claims for payment for those services on my behalf to my insurance carrier. I authorize release of medical information to the insurance carrier or its agents to allow for benefit or claim determination. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Signature: ____ **Date**: ______________________

Parent (if minor): ____ **Date:** ______________________

________ initial

Refraction:

The determination of your best corrected vision is called a ***refraction***. A refraction is used to determine the need for corrective eyeglasses (**valid for 2 year)** or contact lenses (**valid for 1 year)**. This is considered a ***non-covered service*** by most insurance companies. You are responsible for the **$45.00** fee when this service is performed. We will bill this service to your insurance company as a courtesy, and if they pay any portion, you will be refunded their payment amount.

Note Please alert the technician at your appointment if you do not wish to have a refraction done.

________ initial

No Show/Cancellation Policy:

We regret patients must sometimes wait a lengthy time to be seen by a physician. Due to the high demand of appointments and in order to be respectful of the medical needs of all our patients, please be courteous and call our office promptly if you are unable to attend an appointment. We always have patients on a cancellation list that need care.

If you are unable to keep your scheduled appointment, we require 24 hours notice.

If you miss 2 appointments without proper notification, we reserve the right to dismiss the patient from our care.

________ initial

Late Policy:

In order for our clinic schedule to run efficiently, we request that you arrive on time for your appointment. If you know in advance that you will be late, please call the office to notify us. If you are more than 15 minutes late for an appointment and you have not called in advance, you may be asked to reschedule.

Acknowledgment of Notification of Privacy Practices

I hereby give permission to communicate with the following individuals regarding my examination, treatment, and statement of account at Gleason Janky Eye Physicians.

Please list name, relation, and phone number

1.____

2.____

3. ____

Under the Health Insurance Portability and Accessibility Act (HIPAA), we are required to document that you have been given the opportunity to read the Notice of Privacy Practices for Gleason Janky Eye Physicians. A copy of our Notice of Privacy Practices is available upon request. By signing below, you are indicating that you have been given the opportunity to read this document.

Patient Signature ____ **Date:**__________________

Parent (if Minor) ____ **Date:**__________________

***Allergies to Medications:** YES NO**
If yes please list:

***Do you take Aspirin? **Yes No**

Current Medication: **CROSS OUT** the medication that you are no longer taking and **WRITE IN** any new ones not on the list.
Current prescription medications and **over the counter** medications/supplements (may attach list)

Medications			
Cross out any medications that you are no longer taking and list all prescriptions, over the counter and herbal medications			
Date	**Name**	**Strength**	**Directions**