



5729 Esplanade Dr., Corpus Christi, TX 78414  
Phone: (361) 991-3800 Fax: (361) 991-6510

### Medical History Form

Date of Exam : \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male / Female  
Family  
Doctor: \_\_\_\_\_ Last Exam: \_\_\_\_\_ By Dr. : \_\_\_\_\_

#### **EYE HISTORY:**

Previous eye diagnoses: \_\_\_\_\_

Previous eye surgery? YES / NO Describe: \_\_\_\_\_

Previous eye injury? YES / NO Describe: \_\_\_\_\_

Do you wear glasses? YES / NO Contact Lens? YES / NO

#### **PERTINENT MEDICAL HISTORY:**

List all important medical history or problems you have had: \_\_\_\_\_

Have you had any surgeries? YES / NO If yes please explain: \_\_\_\_\_

#### **MEDICATIONS:**

Please list all medication allergies: \_\_\_\_\_

List eye drops/ medications:

List all other Medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### **FAMILY HISTORY:**

Do any of your **blood relatives** have:

Glaucoma?	___ YES	___ NO	Diabetes?	___ YES	___ NO
Macular Degeneration?	___ YES	___ NO	High Blood Pressure	___ YES	___ NO
Retinal Detachment?	___ YES	___ NO	High Cholesterol?	___ YES	___ NO
Blindness?	___ YES	___ NO	Thyroid Disease?	___ YES	___ NO
Arthritis?	___ YES	___ NO	Other?	_____	

**REVIEW OF SYSTEMS**

**CONSTITUTIONAL**

Fever \_\_\_\_\_ YES \_\_\_\_\_ NO  
Weight Loss \_\_\_\_\_ YES \_\_\_\_\_ NO

**EYES**

Blurred Vision \_\_\_\_\_ YES \_\_\_\_\_ NO  
Loss of Vision \_\_\_\_\_ YES \_\_\_\_\_ NO  
Fluctuating Vision \_\_\_\_\_ YES \_\_\_\_\_ NO  
Loss of Side Vision \_\_\_\_\_ YES \_\_\_\_\_ NO  
Double Vision \_\_\_\_\_ YES \_\_\_\_\_ NO  
See Halos \_\_\_\_\_ YES \_\_\_\_\_ NO  
Dryness \_\_\_\_\_ YES \_\_\_\_\_ NO  
Excess tearing, watering \_\_\_\_\_ YES \_\_\_\_\_ NO  
Mattering \_\_\_\_\_ YES \_\_\_\_\_ NO  
Redness \_\_\_\_\_ YES \_\_\_\_\_ NO  
Itching, burning \_\_\_\_\_ YES \_\_\_\_\_ NO  
Glare / light sensitivity \_\_\_\_\_ YES \_\_\_\_\_ NO  
Eye pain \_\_\_\_\_ YES \_\_\_\_\_ NO  
Eyes feel tired \_\_\_\_\_ YES \_\_\_\_\_ NO  
Irritated eye \_\_\_\_\_ YES \_\_\_\_\_ NO  
Problems with night vision \_\_\_\_\_ YES \_\_\_\_\_ NO

**EARS/ NOSE/ MOUTH/  
THROAT**

Sinus congestion \_\_\_\_\_ YES \_\_\_\_\_ NO  
Runny nose/ postnasal drip \_\_\_\_\_ YES \_\_\_\_\_ NO  
Dry mouth/ throat \_\_\_\_\_ YES \_\_\_\_\_ NO

**CARDIOVASCULAR/ HEART**

Chest pain \_\_\_\_\_ YES \_\_\_\_\_ NO  
Irregular heart beat \_\_\_\_\_ YES \_\_\_\_\_ NO

**RESPIRATORY/ LUNGS**

Shortness of breath \_\_\_\_\_ YES \_\_\_\_\_ NO  
Cough \_\_\_\_\_ YES \_\_\_\_\_ NO  
Asthma \_\_\_\_\_ YES \_\_\_\_\_ NO

**GASTROINTESTINAL**

Stomach problems/ ulcers \_\_\_\_\_ YES \_\_\_\_\_ NO

**GENTOURINARY**

Kidney/ bladder problems \_\_\_\_\_ YES \_\_\_\_\_ NO  
Dialysis \_\_\_\_\_ YES \_\_\_\_\_ NO

**HEMATOLOGIC/LYMPHATIC**

Anemia \_\_\_\_\_ YES \_\_\_\_\_ NO  
Bleeding \_\_\_\_\_ YES \_\_\_\_\_ NO  
Swollen Lymph Nodes \_\_\_\_\_ YES \_\_\_\_\_ NO

**MUSCULOSKELETAL**

Joint pain, arthritis \_\_\_\_\_ YES \_\_\_\_\_ NO  
Weakness \_\_\_\_\_ YES \_\_\_\_\_ NO

**SKIN**

Skin Disease / breast disease \_\_\_\_\_ YES \_\_\_\_\_ NO

**NEUROLOGIC**

Seizures \_\_\_\_\_ YES \_\_\_\_\_ NO  
Nerve disorders \_\_\_\_\_ YES \_\_\_\_\_ NO

**PSYCHIATRIC**

Anxiety \_\_\_\_\_ YES \_\_\_\_\_ NO

**ENDOCRINE**

Glandular disorders \_\_\_\_\_ YES \_\_\_\_\_ NO

**ALLERGIC/ IMMUNOLOGIC**

Chronic allergies \_\_\_\_\_ YES \_\_\_\_\_ NO  
HIV +/- AIDS \_\_\_\_\_ YES \_\_\_\_\_ NO

**SOCIAL HISTORY**

Do you smoke? \_\_\_\_\_ YES \_\_\_\_\_ NO  
Do you drink? \_\_\_\_\_ YES \_\_\_\_\_ NO  
Do you use drugs? \_\_\_\_\_ YES \_\_\_\_\_ NO  
Are you pregnant? \_\_\_\_\_ YES \_\_\_\_\_ NO

Any other additional information? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient/ Responsible Party Signature

\_\_\_\_\_  
Date



PATIENT INFORMATION				
Patient Name Last: _____		First _____ M.I. _____		DOB _____
				AGE _____
				M F
Social Security # _____		Marital Status: _____		
		Single _____ Married _____ Divorced _____ Widowed _____		
Address: _____		City: _____		State: _____ ZIP _____
Occupation: _____		Work Phone# _____		Home Phone # _____
Employer: _____		Employer Address _____		
GUARANTOR'S INFORMATION				
Name Last: _____			First _____ M.I. _____	
			Date of Birth: _____	
Occupation: _____		Employer: _____		Social Security # _____
Employer Address: _____			Employer Phone#: _____	
EMERGENCY CONTACTS (in case of an emergency)				
Emergency Contact Name: _____		Relation: _____		Phone #: _____
Emergency Contact Name: _____		Relation: _____		Phone #: _____
OTHER INFORMATION				
Allergies: _____				
Referring Doctor: _____		Family Doctor: _____		
Pharmacy: _____		Pharmacy Phone #: _____		
Reason for Today's Visit: _____				

**PATIENT CONSENT:** By signing this form, you consent to our use and disclosure of Protected Health Information about you for treatment, payment and Health care operations. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy policies available upon request).

**AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION:** I hereby authorize The Eye Institute of Corpus Christi to obtain any medical information or records which will aid in the treatment or diagnosis of my illness. I also authorize The Eye Institute of Corpus Christi to release any information acquired in the course of my examination or treatment to other physicians or to insurance companies.

I give permission for The Eye Institute of Corpus Christi to discuss my Personal health information with the following people:

\_\_\_\_\_  
Print Name and Relationship

\_\_\_\_\_  
Print Name and Relationship

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## Financial Responsibility and Insurance Coverage

<b>PRIMARY INSURANCE INFORMATION</b>
Insurance Company:
<b>SECONDARY INSURANCE INFORMATION</b>
Insurance Company:
<b>TERCIARY INSURANCE INFORMATION</b>
Insurance Company:

**REFRACTION FEE NOTICE: MEDICARE, MEDICAID, TRICARE AND MOST PRIVATE INSURANCES DO NOT COVER THE CHARGE FOR A REFRACTION. (A refraction is the testing done to determine your glasses prescription.) THERE IS A \$50.00 CHARGE YOU WILL BE RESPONSIBLE FOR AT THE TIME OF SERVICE. (Fee will be refunded if your insurance pays for this service.)**

**Assignment of Insurance:** I hereby authorize payment directly to The Eye Institute of Corpus Christi for Surgical and/or Medical Benefits, if any, otherwise payable to me for these services. I understand I am financially responsible for any charges not covered by this assignment

**Financial Responsibility Statement:** By signing this form, I understand that I am responsible for payment of any co-pays, deductibles and/or co-insurances deemed my responsibility by my insurance coverage. The Eye Institute of Corpus Christi will file insurance as a courtesy to our patients. In the event of a surgical procedure I understand that I am to pay these fees prior to my surgery. In the event that I am unable to pay this amount in full, I agree to pay half of the amount upfront and continue making payments monthly until the balance is paid in full. It is the patient's responsibility to update The Eye Institute of Corpus Christi when there are any insurance changes, failure to do so will result in the patient being billed for 100% of the service charge.

**No Insurance Coverage Policy:** By signing this form, I understand that I am responsible for all service rendered. I also understand that since I have no insurance coverage I have been given a discount on my services. I understand that if I fail to make payment in a timely manner, I will be referred to a collection agency and the balance will be reported on my credit report.

**Minor Patients:** The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan.

**No Show Policy:** If you cannot make your appointment please call within 24 hours of your appointment to cancel. If you do not call you are considered a NO SHOW and a \$25 will be charged to your account.

**By signing below I acknowledge all the information on this page is correct. In consideration for the services rendered, or to be rendered, I hereby accept financial responsibility for this account.**

**Signature of Patient or Responsible Party:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**Ravi Krishnan, M.D.**

5729 Esplanade Dr.

Corpus Christi, TX 78414

Phone (361) 991-3800 Fax (361) 991-6510

**AUTHORIZATION FOR DISCLOSURE OF  
CONFIDENTIAL INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Authorizes THE EYE INSTITUTE OF CORPUS CHRISTI to release the following medical information to the named person(s) below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_

Check all that may be released:

- \*\*All Information\*\***                       Diagnosis                       Medications
- Lab Reports                                       X-ray Reports                       Care/Treatment
- Operative Reports                               Psychological Reports                       Other (please Specify)

Confer orally with person (s) listed below about my medical conditions:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

May we contact you at work and/or leave a message?                       YES     NO

May we contact you at home and/or leave a message regarding appointments?                       YES     NO

This authorization shall be valid from the date of signature. The patient can revoke this authorization in writing at any time.

The patient agrees that a photocopy of this authorization may be considered valid.                       YES     NO

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, Antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. Initial: \_\_\_\_\_ Date: \_\_\_\_\_**



## Notice for Possible Non-Payment of Services Provided

Date of Service: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

Other Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

Due to the increase in insurance policy changes, we are requesting all patients to list their current insurance coverage at the time of visit. Please note that some of these insurance companies require a referral or authorization before services are rendered. For most insurances, a week advanced notice is required to obtain such referrals or authorizations. There are some insurance policies that have a set time limit for claims filing. Failure to provide our office with the correct insurance information in a timely manner will result in patient responsibility for all services provided on the date mentioned above. Claims will be submitted to the insurance(s) listed above.

### **Beneficiary Agreement:**

“I \_\_\_\_\_, agree that the insurance information I have provided to The Eye Institute of Corpus Christi above is correct. I understand, if there are any changes in my insurance, I am to notify The Eye Institute of Corpus Christi of all changes in a timely manner. I understand failure to do so will result in my responsibility for payment of services. I also understand, if required by my insurance, that it is my responsibility to make sure a valid referral or authorization from my primary care physician is on file for this service as stated in my insurance policy.”

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Initials



## Non-insured Payment Notice

By signing this form, I agree that the payment I am making to The Eye Institute of Corpus Christi is for services provided by Dr Ravi Krishnan or Dr Ken Kikuchi. It has been explained to me that there may be additional fees charged. I understand that all fees are to be paid in advance. If I am unable to pay the full amount of Dr. Krishnan's or Dr. Kikuchi's fees, I agree to pay a portion upfront (**\$150.00 minimum**) and make monthly payments on the remaining balance until paid in full. I have been informed that if I fail to make payments my account will be referred to a collection agency which will be reported on my credit.

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
Patient / Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Office Staff Signature

\_\_\_\_\_  
Date