PATIENT INFORMATION

Richard S. Kalski, M.D.
Cataract, Corneal & Refractive Surgery
Board Certified Ophthalmologist
James Fleischman, M.D.
General Ophthalmology & Glaucoma
Board Certified Ophthalmologist

7000 S.W. 97th Avenue
Suite 114
Miami, FL 33173
T: 305.665.2023
F: 305.665.2363
www.kalskivision.com
E: kalskivision@aol.com

Patient Last Name:____________________ **First Name:**____________________

Street Address:____________________ **City:**________ **State:**____ **Zip:**______

Home Phone: ____________________ **Mobile Phone:** ____________________

Employer Name:____________________ **Work Phone:** ________________

Employer Address:____________________ **City:**________ **State:**____ **Zip:**______

Personal Email:____

Social Security Number: ________________ **Date of Birth:** ______________ **Age:** _____

Sex: Male____ Female____ Marital Status: Single____ Married____ Divorced____ Widowed____

Family Doctor/Primary Care Physician____________________________

Referred by (Circle One): Insurance / Patient / Physician / Optometrist/Other:____________________

Name & Information of responsible party for Bill and or Holder of Insurance Policy if different from patient

Name:________________________ **Date of Birth:**______________ **Age:**_____

Street Address:____________________ **City:**________ **State:**____ **Zip:**______

Home Phone: ____________________ **Work Phone:** ____________________

Employer Name & Address:____

Relationship to Patient (circle one): Self Spouse Child Other____________________

Name of Primary Insurance:____

Name of Secondary Insurance:____

Please provide us with your insurance card so we can make a photocopy for verification

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I request that payment of authorized benefits be made on my behalf to Richard S. Kalski, M.D. P.A. for any services furnished. I authorize Richard S. Kalski, M.D. or James Fleischman, M.D. to release to my insurance Company, its agents, or any other supplier of medical benefits, any information needed to determine those benefits, or benefits payable for related services. **I understand that if I am seen without a referral from my primary care physician and my health plan requires that I obtain that referral; my health plan may not cover the charges, costs, or expenses of my examination by Richard S. Kalski, M.D. or James Fleischman, M.D. in that case, I will be responsible for paying my bill in addition to co-payments/deductibles.**

Patient Signature:______________________________ Date:________________

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IMPORTANT NOTICE TO OUR PATIENTS

Please be aware that your vision could be temporarily impaired following eye examinations at our office. Eye drops that dilate your pupils may be a necessary part of your exam to assure accurate results and to aid in the diagnosis and treatment of your eye disease. The use of dilating drops as well as other methods of examination and treatment may cause blurred vision, possibly interfering with your ability to drive safely. If your vision is blurred, please feel free to stay in our office until your vision returns to normal. If necessary, our staff can assist you in arranging for alternative transportation. If you have any questions, please ask our staff.

Patient Signature: ______________________________

Witness Signature:______________________________

Date:______________________________

NOTICE TO PARENTS AND LEGAL GUARDIANS

I understand that my child's eyes may be dilated which could temporarily impair vision, Climbing, bike riding and other activities could be potentially dangerous and should be avoided until vision returns to normal. If you have any questions, please ask our staff.

Patient Signature: ______________________________

Witness Signature:______________________________

Date:______________________________

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient Last Name:______________________________ **First Name:**______________________________

Street Address:______________________________ **City:**__________ **State:**_____ **Zip:**________

Social Security Number: _______________ **Date of Birth:** ____________ **Phone Number:** ____________

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.
Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, and the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting

> **Contact Person: Richard S. Kalski, M.D. & James Fleischman, M.D.**
> **Address: 7000 S.W. 97th Avenue Suite 114, Miami, FL 33173**
> **Telephone: 305-665-2023**

Right to Revoke. You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

SIGNATURE
I,____________________________, have had a full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations

Patient Signature:______________________________________ Date:______________________

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Vision Correction Specialist

Date:____________________

Patient Name:____________________ **Primary Care Physician:**____________________

MEDICAL INFORMATION SHEET

Past Ocular History: (Please Mark all that apply) □ **None**

- □ Amblyopia (Lazy Eye)
- □ Cataracts
- □ Diabetic Eye Disease
- □ Dry Eyes
- □ Glasses
- □ Glaucoma
- □ Iritis
- □ Keratoconus
- □ Macular Degeneration
- □ Optic Neuritis
- □ Retinal Detachment
- □ Other:____________________

Ocular Surgeries: (Please Mark all that apply) □ **None**

- □ Blepharoplasty (Eye Lids)
- □ Cataract Surgery
- □ Corneal Transplant
- □ Glaucoma Laser (LPI, Shunt, Istent, SLT)
- □ Ocular Trauma
- □ Punctual Plugs
- □ Refractive Surgery (Lasik, Lasek, RK, PRK)
- □ Retinal Laser Surgery
- □ Strabismus Surgery (Lazy Eye)
- □ Vitrectomy (Retinal Surgery)
- □ Other:____________________

Systemic Illnesses: (Please Mark all that apply) □ **None**

- □ AIDS
- □ Anemia
- □ Asthma
- □ Arthritis
- □ Bleeding Disorder
- □ Cancer
- □ Chicken Pox
- □ COPD
- □ Diabetes
- □ Eczema
- □ Fibromyalgia
- □ Graves disease
- □ Headache
- □ Herpes Simplex
- □ Herpes Zoster/Shingles
- □ Heart Disease
- □ Hearing Loss
- □ Hepatitis A/B/C
- □ High Blood Pressure
- □ High Cholesterol
- □ Kidney Disease
- □ Kidney Stones
- □ Liver Disease
- □ Lung Disease
- □ Lupus
- □ Meningitis
- □ Migraine
- □ MRSA
- □ Multiple Sclerosis
- □ Polymyalgia
- □ Psychiatric Disorder
- □ Rheumatoid Arthritis
- □ Skin Cancer
- □ Stroke
- □ Thyroid Disorder
- □ Other:____________________

Pregnant: (please circle) YES NO NA **Breast Feeding: (please circle) YES NO NA**

Current Eye Medications: (Please List and Print Clearly)

____

____

General Surgeries/Operations: (Please List)

____

____

Current Other Medications including Vitamins: (Please List)

____

____

Family History: (Please Mark all that apply)

☐ Arthritis	☐ Diabetes	☐ Kidney Disease	☐ Stroke
☐ Blindness	☐ Glaucoma	☐ Lazy Eye	☐ Tuberculosis
☐ Cancer	☐ Heart Disease	☐ Macular Degeneration	☐ Other:____________________
☐ Cataracts	☐ High Blood Pressure	☐ Retinal Disease	

Social History: (Please Mark all that apply)

Smoking: ☐ never smoked ☐ current everyday smoker ☐ social smoker (sometimes) ☐ former smoker

☐ Hard of Hearing	☐ Heartburn	☐ Tremors
☐ Ringing in Ears	☐ Jaundice/Hepatitis	☐ Weakness/Paralysis
☐ Vertigo	☐ Nausea/Vomiting	

If you have any questions about this form, or there is other information which you feel might be important, please discuss further with the doctor.

I certify that the above information is correct to the best of my knowledge. I will not hold the doctor or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

________________________________ ________________________

Patient Signature Date

________________________________ ________________________

Physician Signature Date