PATIENT INFORMATION SHEET

Richard S. Kalski, M.D.
Cataract, Corneal & Refractive Surgery
Board Certified Ophthamologist
www.kalskivision.com
E: contactus@kalskivision.com

7000 S.W. 97th Avenue
Suite 114
Miami, FL 33173
T: 305.665.2023
F: 305.665.2363

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:_____

Emergency contact: Name and phone#: _____

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

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. 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. in that case, I will be responsible for paying my bill in addition to co-payments/deductibles.

Patient 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, of 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.
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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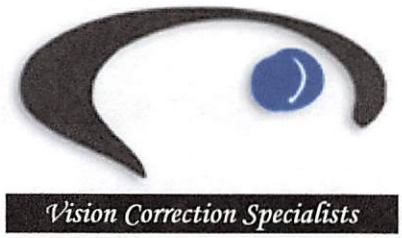

IMPORTANT NOTICE TO OUR PATIENTS

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, my staff can assist you in arranging for alternative transportation. If you have any questions, please ask my staff.

REFRACTION, The procedure to check or determine your Eyeglass prescription, is not covered by Medicare or Private Insurance Companies. **THE CHARGE FOR A REFRACTION IS $50.00. WE DO NOT ACCEPT VISION PLANS. THOSE PLANS REFER TO OPTOMETRISTS.**

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 my staff.

Patient Signature: _____

Witness 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
- □ Glaucoma
- □ Dry Eyes
- □ Glasses
- □ Contact lenses
- □ Iritis
- □ Keratoconus
- □ Optic Neuritis
- □ Retinal Detachment
- □ Macular Degeneration
- □ 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)
- □ Vitrectomey (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
  - □ Pacemaker
  - □ Defibulator
- □ 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 Disease
- □ Other: _____

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

Current Eye Medications: (Please List and Print Clearly)

_____

_____

General Surgeries/Operations: (Please List)

_____

_____

Current Other Medications including Vitamins: (Please List)

_____

_____

EMERGENCY CONTACT NAME AND PHONE # _____

TURN OVER →→→→→→

Family History: (Please Mark all that apply)

□ Arthritis	□ Diabetes	□ Kidney Disease	□ Macular Degeneration
□ Blindness	□ Glaucoma	□ Lazy Eye	□ Tuberculosis
□ Cancer	□ Heart Disease	□ stroke	□ 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

Alcohol: □ Yes □ No If yes, how much and how often?_____

Drug Use: □ Yes □ No If yes, how much and how often?_____

COVID 19: Current and History:

Do you currently have Covid 19? □ Yes □ No If yes, when did you test positive?_____

Have you had Covid 19? □ Yes □ No If yes, please provide date/s_____

If you have any questions about this form, or there is other information which you feel might be important, please discuss 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 his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date