Welcome to ICT Eye, LLC

We are happy you have been referred to ICT Eye, LLC. We look forward to helping you with your specific eye care needs, medical or surgical. Enclosed is information and paper work for you to review and complete. Please fill out **all** enclosed forms to the best of your ability. If possible, mail or bring the forms to our office with the envelope provided before your visit. Your office visit will be much quicker if we receive the information **prior** to your appointment.

Forms to complete and return to our office:

- New Patient Form
- Medical History Form
- Payment Policy Agreement
- ePrescribe Agreement

What to bring:

- Completed forms
- Insurance cards and referral authorization if needed
- All eye drops (over the counter and prescribed)
- A list of all oral medication and supplements

What to expect:

As a new patient you may be at our office between 1.5 to 2 hours depending on your exam requirements. In office testing is usually performed the same day. Procedures and surgeries will be scheduled on a separate visit. We **may** dilate your eyes as part of the exam. Please bring dark glasses and a driver to take you home after your visit. We will provide you with “slip on” dark glasses if needed. If you have any questions about your upcoming exam, please call us at 316-425-0445.

Dr. Jennifer Burgoyne MD

ICT Eye, LLC Office Location:

ICT Eye, LLC is located on 29th St N between Rock Rd and Webb Rd just west of Cypress Surgery Center off the K-96 Webb Street Exit.

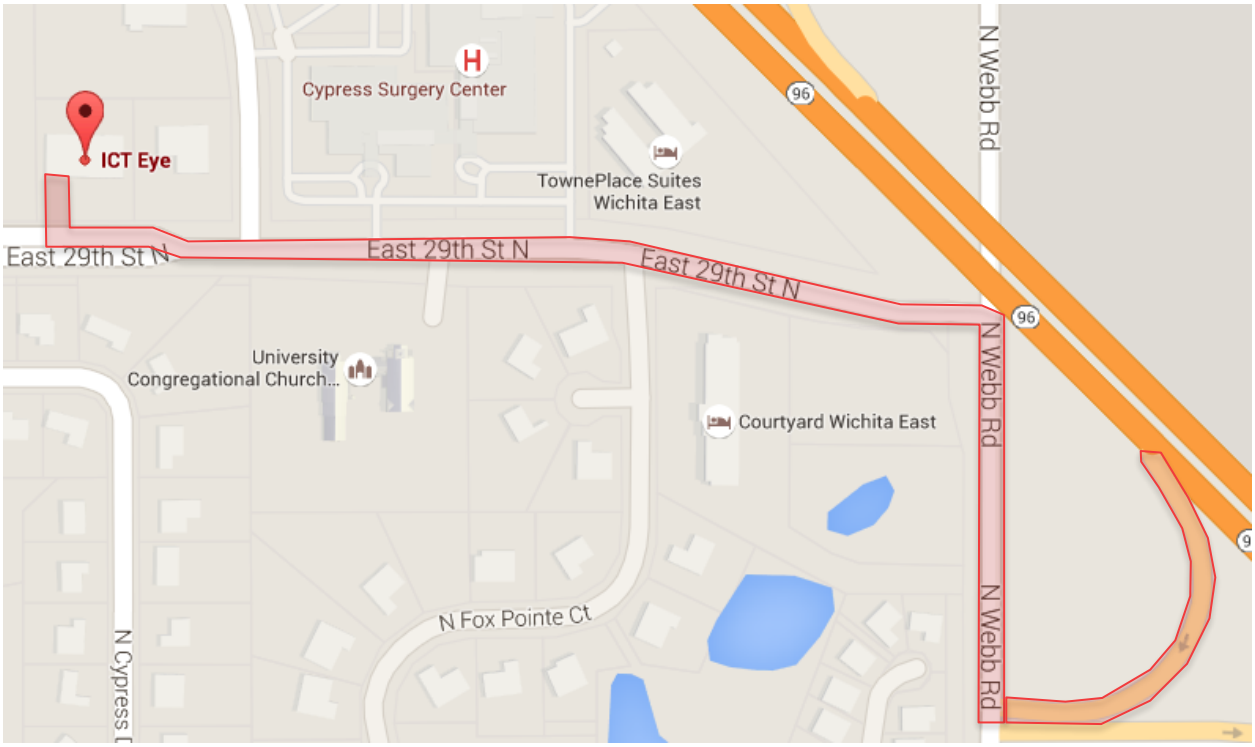
Address:

9050 E 29th St North
Suite 40
Wichita, KS 67226

Phone:

316-425-0445

Google Map:



NEW PATIENT INFORMATION

PATIENT INFORMATION				
NAME (LAST, FIRST, MIDDLE INITIAL)	MARITAL STATUS	SSN#	DATE OF BIRTH	SEX
STREET ADDRESS:	CITY, STATE		ZIP CODE	
PRIMARY PHONE:	ALTERNATE PHONE:	WORK PHONE:	E-MAIL	

RACE: □ American Indian □ Asian □ Black or African American □ Native Hawaiian □ White/Caucasian
□ Other:_____ _____ □ Decline
ETHNICITY: □ Hispanic/Latino □ Non-Hispanic □ Unknown □ Other: _____
PREFERRED LANGUAGE: □ English □ Spanish □ Vietnamese □ Chinese □ Arabic
□ Others:_____

PRIMARY INSURANCE			
NAME OF INSURANCE COMPANY		NAME OF INSURED	
POLICY #	GROUP #	RELATIONSHIP TO PATIENT	DATE OF BIRTH

SECONDY INSURANCE (IF APPLICABLE)			
NAME OF INSURANCE COMPANY		NAME OF INSURED	
POLICY #	GROUP #	RELATIONSHIP TO PATIENT	DATE OF BIRTH

ADDITIONAL CONTACT INFORMAITON

EMERGANCY CONTACT

Name:_____ Relationship:_____

Contact Phone Number:_____

Who can have access to your **medical information**, if you are not able/available to request information?

Name:_____ Relationship:_____

Who can have access to your **billing/insurance information**, if you are not able/available to discuss information?

Name:_____ Relationship:_____

PHYSICIANS		
FAMILY/PRIMARY CARE	EYE DOCTOR/OPTOMETRIST	REFERRING PHYSICIAN

PREEFFERED PHARMACY		
NAME	PHONE NUMBER	CITY OR ZIP CODE

In-Office Use Only: E-Scribe Program: □ Enrolled □ Declined

NEW PATIENT MEDICAL HISTORY FORM

Name:_____ DOB_____

PAST MEDICAL HISTORY

Please check all that apply. Please fill in any necessary blank spot with additional details.

- ☐ **No History of Illness**

- ☐ Anxiety
- ☐ Arthritis
  Type:_____
- ☐ Asthma
- ☐ Irregular Heartbeat (AF)
- ☐ Bone Marrow Transplant
- ☐ BPH (Prostate Enlargement)
- ☐ Breast Cancer
  When:_____
- ☐ Colon Cancer
  When:_____
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Type 1 Diabetes
  Last A1C :_____
- ☐ Type 2 Diabetes
  Last A1C :_____
- ☐ Kidney Failure (ESRD)
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
  Type:_____
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Thyroid Disorder
  - Hypo-
  - Hyper-
- ☐ Leukemia
- ☐ Lung Cancer Year:_____
- ☐ Lymphoma
- ☐ Prostate Cancer Year:_____
- ☐ Radiation Treatment
- ☐ Seizure
- ☐ Stroke Year:_____
- ☐ Skin Cancer Year:_____
  Location:_____
- ☐ Sjogren's
- ☐ Heart Attack Year:_____

- ☐ Other:_____

_____

_____

PAST SURGICAL HISTORY

Please check and circle all that apply. Please fill in year of surgery.

- ☐ **No Surgical History**

- ☐ **Appendix** Year:_____
- ☐ **Bladder** Year:_____

Breast

- ☐ *Biopsy*: LT / RT / Both
  Year:_____
- ☐ *Lumpectomy*: LT/ RT / Both
  Year:_____
- ☐ *Mastectomy*: LT/ RT / Both
  Year:_____

Colon

- ☐ *Cancer Resection* Year:_____
- ☐ *Colon Diverticulitis* Year:_____
- ☐ *IBS* Year:_____
- ☐ *Colostomy* Year:_____

- ☐ **Gallbladder** Year:_____

Heart

- ☐ *Coronary Bypass* Year:_____
- ☐ *Transplant* Year:_____
- ☐ *Pacemaker* Year:_____
- ☐ *PTCA*

Joint Replacement

- ☐ *Hip* LT / RT / Both
  Year:_____

Joint Replacement

- ☐ *Knee* LT / RT / Both
  Year:_____

Kidney

- ☐ *Biopsy* Year:_____
- ☐ *Stone Removal* Year:_____
- ☐ *Transplant* Year:_____
- ☐ *Nephrectomy* Year:_____

Liver

- ☐ *Hepatectomy* Year:_____
- ☐ *Transplant* Year:_____
- ☐ *Shunt* Year:_____

Ovaries

- ☐ *Endometriosis* Year:_____
- ☐ *Cancer* Year:_____
- ☐ *Cyst* Year: _____
- ☐ *Tubal Ligation* Year:_____

Pancreas

- ☐ Year:_____

Prostate

- ☐ *Biopsy* Year:_____
- ☐ *Cancer* Year:_____
- ☐ *TURP* Year:_____

Rectum

- ☐ APR Year:_____
- ☐ Low Anterior Resection Year:_____

Skin

- ☐ *Basal Cell* Year:_____
- ☐ Location:_____
- ☐ *Melanoma* Year:_____
- ☐ Location:_____
- ☐ *Biopsy* Year:_____
- ☐ Location:_____
- ☐ *Squamous Cell* Year:_____
- ☐ Location:_____

- ☐ **Spleen** Year:_____
- ☐ **Testicles** Year:_____

Uterus

- ☐ *Hysterectomy* Year:_____
- ☐ *Fibroids* Year:_____
- ☐ *Cancer* Year:_____

Other Surgeries:

_____

_____

_____

_____

_____

_____

~Please Turn Over ~

PAST OCULAR HISTORY

Please check all that apply. Please fill in any necessary blank spot with additional details.

	Eye		Eye		Eye
Cataract	□ L □ R	Glaucoma	□ L □ R	Retinal Tear	□ L □ R
Corneal Dystrophy	□ L □ R	Macular Degeneration	□ L □ R	Strabismus	□ L □ R
Diabetic Retinopathy	□ L □ R	Ocular Hypertension	□ L □ R	Floaters	□ L □ R
Dry Eye	□ L □ R	Ophthalmic Migraine	□ L □ R	Other: _____	

PAST OCULAR SURGERY

Please check and circle all that apply. Please fill in year of surgery.

□ **No Surgical History**

Eyelid _____
□ L Year:_____ □ R Year:_____

Cataract _____
□ L Year:_____ □ R Year:_____

Corneal Transplant
□ L Year:_____ □ R Year:_____

DSAEK/SMEK_____
□ L Year:_____ □ R Year:_____

Eye Muscle_____
□ L Year:_____ □ R Year:_____

Intravitreal Injections_____
□ L Year:_____ □ R Year:_____

LTP_____
□ L Year:_____ □ R Year:_____

PRK_____
□ L Year:_____ □ R Year:_____

Ptosis Repair _____
□ L Year:_____ □ R Year:_____

Punctual Plugs_____
□ L Year:_____ □ R Year:_____

Strabismus_____
□ L Year:_____ □ R Year:_____

Retinal Laser _____
□ L Year:_____ □ R Year:_____

Trabeculectomy_____
□ L Year:_____ □ R Year:_____

Tube shunt_____
□ L Year:_____ □ R Year:_____

YAG Laser_____
□ L Year:_____ □ R Year:_____

Lasik_____
□ L Year:_____ □ R Year:_____

Other

_____
□ L □ R Year:_____

_____
□ L □ R Year:_____

_____
□ L □ R Year:_____

MEDICATION AND SUPPLEMENTS

List all medication you are currently taking: Name, Dose, Frequency, and Reason for use.
Please include all prescriptions, over the counter medication, and vitamin/supplements.

NAME	DOSE	FREQUENCY	REASON FOR USE

MEDICATION ALLERGIES

Please list all known allergies, severity, and the reaction if medication is take. Or check the following statement: □ **NONE** I have no known allergies to medication

ALLERGY	SEVERITY (Mild/Moderate/Severe)	REACTION

SOCIAL HISTORY

Please check all that apply. Please fill in any necessary blank spot with additional details.

Smoking Status (Please Choose One)

□ Never smoked

□ Current everyday smoker

Stared Smoking:_____

Pack Per Day:_____

□ Current someday smoker

Stared Smoking:_____

Pack Per Month:_____

□ Former smoker

Stared Smoking:_____

Quit Smoking:_____

Alcohol Intake (Please Choose One)

□ None

□ 1 or less per day

□ 1-2 per day

□ 3 + per day

If you are over 65, how many times this year have you had 5 or more drinks in 24 hours? _____

Residence Information

□ Alone

□ With Family

□ Assisted Living

□ Nursing Home

Marital Status

□ Single

□ Married

□ Widowed

□ Divorced

FAMILY HISTORY

Please check all that apply. *M = Mother F=Father B= Brother S=Sister*

Diabetes: □ M □ F □ B □ S

High Blood Pressure: □ M □ F □ B □ S

Glaucoma: □ M □ F □ B □ S

Blindness: □ M □ F □ B □ S

Cataract: □ M □ F □ B □ S

Strabismus: □ M □ F □ B □ S

Heart Disease: M F B S

Migraine: M F B S

Cancer: M F B S

CVS : M F B S

Macular Degeneration: M F B S

Retinal Detachment: M F B S

Other: _____

□ M □ F □ B □ S

Other: _____

□ M □ F □ B □ S

Other: _____

□ M □ F □ B □ S

OUR PAYMENT POLICY

If you are covered by an insurance plan, please present your current insurance card(s) to the receptionist at the time of your first visit. If your insurance changes at any time, you must present the new card(s) to the receptionist at your next visit after the change. Our staff must have current information in order to process your claims. Because of the numerous insurance plans available, we will not be able to answer specific questions regarding your plan. Please contact your insurance company for plan specific information.

If you are not covered under an insurance plan, we will provide assistance to you by making arrangements for payment that will fit your individual circumstances. You may call our office for an estimated amount of service costs prior to your visit. Payment will be due at the time of service. We accept check, Visa, MasterCard, and Discover.

1. It is ***your*** responsibility to check with your insurance company prior to your first visit to determine if we are a participating physician with your insurance plan. Medicare Standard **does not** require a referral. HMO's such as Premier Blue, Coventry, Blue Select, and others **may** require a referral.

2. If ***your*** insurance plan requires you to have a referral from your primary physician, ***you*** are responsible for contacting your physician before each visit to our office. Please ask your physician to fax or mail a copy of the referral to our office prior to your visit. If you do not have an authorized referral, we will not refuse you care. However, our office and your insurance company recognize that without a referral, **you** are responsible for any charges related to services provided. We will bill you directly for charges not covered by a referral.

3. If your insurance plan requires a co-payment for your office visit, you will be expected to pay the co-pay amount at the time services are provided. You will be billed for any portion of services not covered by your insurance plan and for deductibles that are a part of your insurance plan. For your convenience, check, VISA, MasterCard, and Discover are accepted.

Our staff is committed to assisting you. If you have any questions, please ask.

I HAVE READ, AND I UNDERSTAND THE ABOVE PAYMENT POLICY

X_____ _____

Patient /Guarantor Signature Date

Updated 2/2016

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribing is a way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and Benefit Transactions** – This gives the health care provider information about which drugs are covered by your drug benefit plan.

- **Fill Status Notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.

- **Medication History Transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at ICT EYE, LLC as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS.

As part of this Consent Form, you specifically consent to the release of this and other sensitive health information. By signing this consent form you are agreeing that your provider at ICT EYE, LLC may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services.

You also have a right to receive a copy of this form after you have signed it. This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to ICT EYE,LLC to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patients Name:_____ Date:_____

Patient or Guardian Signature:_____