



FAMILY EYECARE & CONTACT LENS CENTER LLC

Kirk D. Kvitle, O.D.
727 Broadway Street
Quincy, Illinois 62301
(217) 231-3937

Welcome to Our Office

Name _____
Street _____
City _____ State _____ Zip _____
Home Phone _____
Social Security Number _____
Employer _____
Employer Phone _____
Occupation _____
Hobbies _____
Email Address _____
Today's Date _____ Date of Last Exam _____
Name of Doctor who examined _____
Date of Birth _____ Age _____ Sex: Male Female
What is the purpose of your visit today? _____
Spouse (or parent) name _____
Spouse (or parent) work phone _____

Vision Insurance: Medicare Medicaid
 VSP Blue Cross
 Flex Plan
 Other _____

How will you settle your account today?
 Check Cash Credit Card Financing

List of other family members (spouse, children, etc.)
Mark boxes if patients of Family EyeCare Center (Dr. Kvitle)

Diagnostic Issues

Please list any complaints about wearing glasses or contacts?

- Do you have more than 1 pr. of current Rx Glasses? No Yes
- Is there anything you would like to change about your current eyewear? No Yes
- Do you work on a computer for long periods? No Yes
- If you wear glasses, would you benefit from thinner, lighter lenses? No Yes
- Do you feel the need for sunglasses? No Yes
- Are you interested in a "test drive" of the latest in contact lens design(s)? No Yes
- Laser vision correction is a common choice to reduce or eliminate the need for glasses or contacts. Do you desire information regarding laser vision correction and/or a free evaluation regarding your candidacy? No Yes

Do You Experience...

- Any discomfort with your eyes? No Yes
- Problems with glare or reflection? No Yes
- Sensitivity to light? No Yes
- Headaches? No Yes
- Floater or flashes of light? No Yes

How did you hear about our office?

- Friend or relative. Who? _____
- Another health care practitioner. Who? _____
- Yellow pages. Which directory? _____
- Newspaper advertisement. Which paper? _____
- Radio advertisement. Which station? _____
- Previous patient. Who? _____
- Participating eye care plan. _____
- Other _____

CONSENT FOR TREATMENT

Dr. Kirk Kvitle is herewith authorized to render service, medication and treatment as necessary. I assume full financial responsibility for any bills incurred. Dr. Kirk Kvitle is a participating Medicare provider.

INSURANCE RELEASE

I authorize the release of medical information contained in my medical records to family physicians and/or insurance companies. A photocopy of this authorization shall be as valid as the original. I assume responsibility for any balance above insurance.

MEDICARE LIFETIME CONSENT

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Kirk Kvitle for any services furnished by that physician. I authorize any holder of medical information about me to release to the Health Care Administration and its agents any information needed to determine these benefits or the benefits payable to the related services.

SIGNED _____ DATE _____

MEDICARE NUMBER (IF APPLICABLE) _____

**PAYMENT FOR SERVICES IS EXPECTED AT THE TIME SERVICES ARE RENDERED.
ARRANGEMENTS SHOULD BE MADE FOR EXCEPTIONS.**