FAMILY EYECARE & CONTACT LENS CENTER LLC

Kirk D. Kvitle, O.D.
Jason M. Kvitle, O.D.
3325 Maine Street
Quincy, Illinois 62301
(217) 231-3937

Welcome to Our Office

Name _____

Street _____

City _____ State _____ Zip _____

Home Phone _____

Cell Phones _____ Ok to Text ❑ Yes ❑ No

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

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

Floaters or flashes of light? No Yes

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

_____ ❑
_____ ❑
_____ ❑
_____ ❑
_____ ❑
_____ ❑
_____ ❑

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/Dr. Jason Kvitle are herewith authorized to render service, medication and treatment as necessary. I assume full financial responsibility for any bills incurred. Dr. Kirk Kvitle/Dr. Jason Kvitle are participating Medicare providers.

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/Dr. Jason 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.

ANY ACCOUNT WITH A BALANCE OVER 90 DAYS WILL BE SENT TO COLLECTIONS UNLESS ARRANGEMENTS HAVE BEEN MADE.