



**Dr. Kyle Craig**

1701 S Peoria Ave, Suite 200 Tulsa, OK 74120  
Phone: 918.599.0202 Fax: 918.599.0279

*In order to serve you properly, our staff needs the following information. This information is confidential.*

Today's Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date of Last Eye Exam: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_ M \_\_\_ F \_\_\_

Goes by: \_\_\_\_\_ Marital Status (circle): Married Single Widowed Divorced

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Parent / Spouse: \_\_\_\_\_ Employer: \_\_\_\_\_

Parent / Spouse work phone: \_\_\_\_\_

**Method of Payment/ Insurance Information:**

Insurance \_\_\_ Medicare \_\_\_ Medicaid \_\_\_ Check \_\_\_ Cash \_\_\_ Credit Card \_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insured DOB: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Member ID: \_\_\_\_\_ Member SSN: \_\_\_\_\_ Group #: \_\_\_\_\_

Do you have a Secondary Insurance? Yes \_\_\_ No \_\_\_ (If yes, please complete the following)

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insured DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Member Insurance Company: \_\_\_\_\_

Member ID: \_\_\_\_\_ Member SSN: \_\_\_\_\_ Group #: \_\_\_\_\_

**Authorization & Release:**

I hereby assign and authorize my insurance carrier(s) to issue payment (checks) directly to Midtown EyeCare for medical and/or visual services rendered or my dependents. I understand that I am responsible for any billed amount not covered by insurance. I authorize release of any information concerning my or my child care, advice given, and treatment provided for the purpose of evaluating claims for insurance benefits and agrees to allow a photocopy of my signature to be used to produce insurance claims.

Signature of Patient \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent or Responsible Party \_\_\_\_\_ Date: \_\_\_\_\_



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## HIPPA

### **Our Notice of Privacy Practices:**

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this Notice at any time as allowed by law. If we change this Notice, the new Privacy practices will apply to your health information that we may generate in the future. If we change our Notice of privacy practices, we will post the new copy in our office and have copies available to you in our office.

### **Appointment Reminders:**

We may call or write you of scheduled appointments, or that it is time to make a routine appointment. We may call or write you of other treatments or services available at our office that might help you.

### **Other Uses and Disclosures:**

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form". The content of an "authorization form" is determined by federal law. We may initiate the authorization process if the use or disclosure is our idea, and you may as well initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us properly completed authorization form, or you can use one of ours.

*For additional information, please ask.*

### **ACKNOWLEDGE OF RECEIPT:**

I acknowledge that I understand the copy of Dr. Kyle Craig's Notice of Privacy Practices:

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Must be signed by a parent or guardian if patient is a minor)

## History and Physical Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Date of last medical exam: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have any allergies to medications?  Yes  No If yes, please explain

Current Medications: (if you have a list we would be happy to make a copy)

Please list any previous surgeries and year: \_\_\_\_\_

### Please comment if applicable:

- Heart Problem:  Heart Attack, what year \_\_\_\_\_  Irregular Heartbeat
- Murmur  Pacemaker  other: \_\_\_\_\_
- High blood pressure:  Stroke when? \_\_\_\_\_
- Lungs:  Asthma  Emphysema/COPD  Bronchitis  TB
- Seasonal allergies:  other: \_\_\_\_\_
- Liver Disease:  Hepatitis: type \_\_\_\_\_  Jaundice  other: \_\_\_\_\_
- Kidneys:  Dialysis  Transplant
- Diabetes:  Diet Control  Oral Meds  Insulin  Insulin Pump
- Other: \_\_\_\_\_
- Digestive Disorders:  Ulcer  Hiatal Hernia  Acid Reflux  Other: \_\_\_\_\_
- Arthritis  Bleeding Disorder
- Have you ever been exposed or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis  none
- If female of childbearing years:  I am not pregnant  I am pregnant
- Possibility that I am pregnant

**Family History**

*Please note any family history (parents, grandparents, siblings, children (living or deceased) of the following: Please specify family member in space provided.*

Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cataract	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Crossed Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Retinal Detachment/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

**Please Circle any of the following you have had:**

- |                 |           |                 |                |          |
|-----------------|-----------|-----------------|----------------|----------|
| crossed eyes    | lazy eye  | drooping eyelid | prominent eyes | glaucoma |
| retinal disease | cataracts | eye infections  | eye injury     |          |

**Please Comment if Applicable:**

I have:  Contacts.      When was the last time you wore contacts? \_\_\_\_\_

I have:  Glasses.      How old is your current pair of lenses? \_\_\_\_\_

I smoke:  Cigarettes  Cigar  Pipe      How much and for how long? \_\_\_\_\_

I drink alcohol:  daily  weekly  occasionally