127 S. 4th St
Albion, NE 68620
402-395-2082
402-741-3400
palmereyecarepc.com

Online Intake

1. **Please enter the patient's legal name and contact information.**

First Name: ______ Middle Initials: ______ Last Name: ______ Date of Birth: ______

Gender:
○ Female ○ Male

Nickname ______

Social Security Number: ______

Occupation ______

Place of Employment ______

Mobile Phone: ______ Home Phone: ______ Work Phone: ______ Email: ______

Preferred contact method:
○ Mobile Phone ○ Home Phone
○ Work Phone ○ Email

Spouse Name: ______

Marital Status:
○ Single ○ Married
○ Domestic Partner ○ Separated
○ Divorced ○ Widowed

Street Address: ______ City: ______ State: ______ Zip Code: ______

Is patient a minor?
○ Yes ○ No

2. **If a minor, parent's information**

Father's name: ______ Employer: ______ Work Phone: ______

Mother's name: ______ Employer: ______ Work Phone: ______

3. **Do you have Medical Insurance? Your medical insurance will be billed if you have any eye disease such as: macular degeneration, glaucoma, cataracts, or dry eyes. Medical insurance may be billed if you have any medical eye symptoms such as: red, itchy, watery, dry, painful eyes or blurred vision.**

○ Yes

○ No

4. **Primary Medical Insurance**

Primary Medical Insurance Company

Member ID / Policy #

Group Number

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name

Insured Date of Birth

Do you have secondary medical insurance?
○ Yes ○ No

5. **Secondary Medical Insurance**

Secondary Medical Insurance Company

Member ID / Policy #

Group Number

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name

Insured Date of Birth

6. **Vision Care Plan (VCP): these plans only apply to services that do not yield a medical eye concern and have benefits towards materials for glasses/contact lenses.**

Primary Insurance Company

Member ID/Policy/Social Security Number of Policy holder

Group Number

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name

Insured Phone #

7. **Do you have an insurance card?**

○ Yes

○ No

8. **INSURANCE CARDS: Please upload a picture of both the front and back of your insurance card(s).**

What eye and/or vision concerns do you have?

9. **Problem 1:**

Please describe the issue you're experiencing:

How long have you had this problem?

How severe is this problem?
○ Mild ○ Moderate ○ Severe

Have you tried anything to treat this problem?

10. Do you have any of the following symptoms? (Check all that apply)

- ☐ Watery eyes
- ☐ Eye fatigue/strain after computer use or reading
- ☐ Headaches
- ☐ Dry eyes
- ☐ Flashes
- ☐ Floaters
- ☐ Itchy Eyes
- ☐ Double vision
- ☐ Red eyes
- ☐ Difficulty seeing when driving in bright sunlight
- ☐ Difficulty seeing at night

11. Please fill in information about your regular medical doctor and pharmacy.

Primary Care Provider:

____

Other Provider (endocrinology, rheumatology, oncology, other):

____

Pharmacy:

____

Medical History

Do you have any problems with the following? Please check the correct box:

12. Constitution:

- ☐ Negative
- ☐ Developmental Disabilities
- ☐ Cancer

Other condition, not listed

____

13. Ear/Nose/Throat

- ☐ Negative
- ☐ Hearing Loss
- ☐ Sinus problems

Other Condition, not listed

____

14. Neurological:

- ☐ Negative
- ☐ Multiple Sclerosis
- ☐ Migrane
- ☐ Parkinson's
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Numbness or weakness

Other condition, not listed

____

15. **Psychiatric:**

- ☐ Negative
- ☐ Depression
- ☐ Anxiety
- ☐ ADD/ADHD
- ☐ Bipolar

Other condition, not listed

____

16. **Cardiovascular:**

- ☐ Negative
- ☐ Heart Disease
- ☐ High Blood Pressue
- ☐ Stroke/CVA
- ☐ High Cholesterol

Other condition, not listed

____

17. **Respiratory:**

- ☐ Negative
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea

Other condition, not listed

____

18. **Gastrointestinal/Genitourinary**

- ☐ Negative
- ☐ Crohns Disease
- ☐ Irritable Bowl Syndrome
- ☐ Acid Reflux
- ☐ Pain or discomfort

Other condition, not listed

____

19. **Musculoskeletal:**

- ☐ Negative
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Ankylosing Spondylitis

Other condition, not listed

____

20. **Skin:**

- ☐ Negative
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Eczema

Other condition, not listed

____

21. **Endocrine:**

- ☐ Negative
- ☐ Type 2 Diabetic
- ☐ Type 1 Diabetic
- ☐ Hypothyroid
- ☐ Hyperthyroid

Other condition, not listed

___

22. **If you are diabetic, please answer the following questions**

When were you diagnosed as diabetic?

___

What is your fasting blood sugar?

___

What was your last a1c?

___

Date of last a1c?

___

23. **Hematology:**

- ☐ Negative
- ☐ Bleeding issues
- ☐ Anemia

Other condition, not listed

___

24. **Immunology:**

- ☐ Negative
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjogren's Syndrome

Other condition, not listed

___

25. **Medications:**

Do you take any medications

☐ Yes ☐ No

If yes, what medications? If list is too long, upload list or image of list below.

___

Any supplements/vitamins or over the counter eye drops?

___

26. **Use this to upload a document or image of your medication list if desired.**

27. Do you have any allergies to medications, seasonal allergies, or environmental allergies?

- No
- Yes

28. If so, what allergies?

- penicillin
- sulfa antibiotics
- aspirin
- latex
- seasonal allergies
- animal dander

others not listed

____

29. Ocular Health History

- Glaucoma
- Macular degeneration
- Cataracts
- History of retinal detachment
- Amblyopia (lazy eye)
- Strabismus (eye turn)
- Keratoconus

Other eye conditions not listed

____

30. Eye Surgeries

- Cataract
- LASIK / PRK
- Retinal
- Corneal
- Glaucoma
- Strabismus (eye straightening)

Other eye surgeries not listed

____

31. Last Eye Exam

Date of last eye exam ______________________________

Who was your last eye doctor? ______________________________

Have you been a patient of Dr. Kuester previously? ______________________________

32. Do you wear glasses?

- Yes
- No

33. If yes, please specify:

- all the time
- driving
- reading
- computer use
- TV
- before bed

34. Do you wear contacts?

- ○ Yes
- ○ No
- ○ No, but I am interested in contacts

35. Current contact lens wearers:

What brand of contact lenses do you wear? List the power and base curve (B.C.) of your contact lenses or bring your boxes/extra set to your appointment.

____

If currently wearing contact lenses- select what applies to you

- ○ I'm happy with my current contact lenses
- ○ I'm having some irritation
- ○ My eyes are getting dry
- ○ I'm struggling to see clearly at different distances
- ○ I'm not replacing them when Doctor told me
- ○ I'm interested in a contact lens that is easy to take care of

36. Are you currently pregnant?

- ○ Yes
- ○ No

37. Do you drink alcohol?

- ○ Yes
- ○ No

Frequency:

____

38. Do you smoke?

- ☐ Never ______________
- ☐ Past Smoker ______________
- ☐ Current Smoker ______________

Family Eye & Medical History

39. **Do you have a family (parent, sibling or child) history of:**

	Yes	No	If yes, who?
Glaucoma	Yes	No	
Macular Degeneration	Yes	No	
Strabismus (eye turn)	Yes	No	
Amblopia (lazy eye)	Yes	No	
High Blood Pressure	Yes	No	
Diabetes	Yes	No	
Stroke	Yes	No	
Thyroid problems	Yes	No	

Other relevant conditions:

____

The above information is true to the best of my knowledge.

______________________________ Signature

______________________________ Date