Sam N. Cohlmia, MD
Wichita Ophthalmology, P.A.
9449 E. 21st Street
Wichita, Kansas 67206

Patient Registration

Patient Name (Last, First, Middle)		Social Security #	
If Minor Name of Parent		Email Address:	
Address		City	State / Zip Code
Home Phone	Cell Phone	Work Phone	
Age / Date of Birth	Sex ___ M ___ F	Marital Status __ Married __ Single __ Widowed __ Divorced	
Employer	Occupation	Work Phone	
Employer's Address	City	State	Zip Code
Emergency Contact		Home Phone	
Relationship	Cell Phone	Work Phone	
Primary Care Physician		Phone #	
Who Referred you to our office			
Your Preferred Pharmacy	Address	Phone #	

Medical Insurance Information

Primary Insruance	Secondary Insurance
Name of Insurance Company	Name of Insurance company
Ins. Policy Number Group Number	Ins. Policy Number Group Number
Address	Address
City / State Zip Code	City / State Zip Code
Policy Holder Name Relationship	Policy Holder Name Relationship
Policy Holder's Date of Birth and Soc. Sercuity #	Policy Holder's Date of Birth and Soc. Sercurity #

Release Authorization

I hereby authorize Wichita Ophthalmology, P.A. to release any inforamtion requested with regard to processing my claims to any insurance company, organization, employer, hospital, physican or pharmacist. Wichita Ophthalmology Physician and staff are released from legal responsibility or liability of the released information. I give authorization for payment of insurance benefits to be made directly to Wichita Ophthalmology, P.A. and any assisting that I am financially responsible for all charges whether or not they are covered by my insurance. In the event of default, I agree to pay all costs of collection, and resasonable attorney's fee. I hereby authorize this healthcare provider to release all inforamtion necessary to secure the payment of benefits. I understand that no guarantees have been made to me regarding the outcome of this care. I agree a photocopy of this agreement shall be valid as the original. I certify that the information, I furnish is true and correct. I know it's a crime to fill out this form with facts that I know are false or leave out facts that are important.

Signature **Date**

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PATIENT HISTORY RECORD

Patient Name: _____ DOB: _____ Today's Date: _____

I was referred by: _____ Optometrist: _____

Family Physician: _____ Other Physicians: _____

Please answer the following questions about your medical status and history:

1. Please mark any medical conditions/diseases you currently have or have had:
   ☐ diabetes, ☐ high blood pressure, ☐ arthritis, ☐ bleeding problems, ☐ respiratory, ☐ heart disease, thyroid, ☐ cancer – list type: _____ ☐ other: _____
2. Have you ever had a heart attack? ☐ Yes ☐ No If YES, when: _____
3. Have you ever had a stroke? ☐ Yes ☐ No If YES, when: _____
4. Mark any eye problems you have been diagnosed with: ☐ Cataracts, ☐ Glaucoma, ☐ Macular Degeneration, ☐ Retinal Detachment, ☐ Wandering or "lazy" eye, ☐ other: _____
5. EYE SURGERIES: _____
6. OTHER SURGERIES: _____

ALLERGIES: ☐ **No known allergies.** ☐ **YES** If YES, list type of medicine/food & reaction.

Medication/Food Reaction

CURRENT MEDICATIONS: List prescription & over-the-counter medications and dosage.

FAMILY AND SOCIAL HISTORY:

- List any medical/eye diseases which run in your family: ☐ Diabetes, ☐ Glaucoma, ☐ Cataracts, ☐ Thyroid, ☐ Macular Degeneration, ☐ Heart Disease, ☐ High Blood Pressure, ☐ Respiratory, ☐ Arthritis. ☐ Cancer – list type: _____ ☐ Other: _____
- Do you smoke? ☐ Yes ☐ No If YES, how much? _____
- Do you drink alcohol? ☐ Yes ☐ No If YES, how much? _____

EYE SURGERIES/Updates by Dr. Cohlmia: (office use only) _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge I have received a copy of **WICHITA OPHTHALMOLOGY,P.A** Notice of Privacy Practices.

I give **WICHITA OPHTHALMOLOGY, P.A** permission to leave a message on my answering machine or with a third person who answers my telephone concerning a scheduled appointment reminder.

Check one: ☐ Yes ☐ No

If yes: Telephone Number to be called: _____

Alternate Number to be called: _____

We often are contacted by a patient's family member or friend and asked to report on the patient's condition, or to provide information concerning charges and payment for services provided. If you are present at the time a family member requests such information, we may ask you whether you want us to share information with your family member or friend. If you are not present at the time such a request is made by a family member (e.g., over the phone), we will follow your prior instructions in determining whether we should share any information. If you have not provided any such instruction, we will contact you before providing any specific response to an inquiry from a family member or friend.

Concerning payment: I give permission for **WICHITA OPHTHALMOLOGY, P.A** to discuss insurance, billing and accounting issues with the following person:

Name: _____ Relationship: _____

Please check the following:

☐ Do not share information with family members except in emergency situations

☐ Share information with my spouse only, unless I specifically direct you not to share certain information with my spouse.

My spouse's name is: _____

☐ Share information with the following family members or friends upon their request, unless I specifically direct you not to share certain information:

NAME	RELATIONSHIP

_____ _____
Signature of Patient or Patient Representative Relationship to Patient

_____ _____
Type Patient Name Date

Wichita Ophthalmology, P.A.
Notice of Privacy Practices

Dear Patient,

We are required by law to provide the Notice of Privacy Practices and obtain your acknowledgement of its receipt prior to providing any service to you. We are required to maintain the privacy of your protected health information (PHI). This Notice applies to all records and services received at Wichita Ophthalmology. This Notice will describe the way in which we may use and disclose your PHI. The Notice also describes your rights and certain obligations that we have regarding the use and disclosure of your PHI.

The following is a brief summary of the contents of the Notice. Please feel free to ask any questions you may have concerning its contents.

Your Rights Regarding Your Health Information. This section describes the following rights you have with respect to your PHI and tells how you may exercise these rights:

Right to inspect and copy
Right to request amendment
Right to an accounting of disclosures
Right to request restrictions on certain uses and disclosures
Right to request alternative means of communication
Right to receive a paper copy of our Notice of Privacy Practices

How To File Complaints Concerning Our Privacy Practices. This section tells you what you can do if you believe any of your rights have been violated. You will not be penalized for filing any complaint

How We May Use and Disclose Health Information About You Without Your Specific Authorization. This section describes the different ways we may use of disclose your health information without first obtaining from you a specific authorization. Federal law specifically permits these types of uses and disclosures because it is assumed you would want us to use or disclose your information for these purposes, or because such use or disclosure is recognized as critical to the proper functioning of our health care system.

You will be asked to acknowledge your receipt of this Notice, and your acknowledgement will be maintained in your permanent record. You should keep this copy of the Notice. Another copy of this Notice will not be provided automatically at any later visit, but you may request a copy of the Notice at any time. Also, the Notice is posted at our facility and on our website for your review. If there is a material revision to the Notice at some later date, you again will be provided with a copy of the Notice and asked to sign an acknowledgment.

Maintaining the privacy of your health information is very important to us. Again, if you have any questions concerning the Notice of Privacy Practices, please do not hesitate to ask.

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CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program

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

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.

- **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.

Consent

By signing this consent form, you are agreeing that your provider may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors 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 **Wichita Ophthalmology, P.A** 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.

_____ Print Patient Name _____ Patient DOB

_____ Signature of Patient or Guardian _____ Today's Date

_____ Relationship to Patient