



Holly D. Kent, M.D.
Colorado Corneal Surgeons
 Eye Physician & Surgeon
 Specializing in Cornea & External Disease

Web: www.coloradocornea.com
 Email: drkent@coloradocornea.com

Patient History Form

Patient Name _____ Date _____
 Birth Date _____ Referred By _____

REVIEW OF SYSTEMS

Do you currently have any of the following problems?

If yes, please explain

1. Please list medications you are taking, including eye drops.		1. 2. 3. 4. 5. 6. 7. 8.	
2. Do you have any allergies to any medication?	yes <input type="checkbox"/>	no <input type="checkbox"/>	
3. Have you recently had any chronic fever, unexpected weight loss/gain, or fatigue?	yes <input type="checkbox"/>	no <input type="checkbox"/>	
4. Eyes (glaucoma, cataract, lazy eye, retina problems, other)	yes <input type="checkbox"/>	no <input type="checkbox"/>	
5. Ear / nose / mouth / throat (hearing loss, sinus problems, sore throat)	yes <input type="checkbox"/>	no <input type="checkbox"/>	
6. Cardiovascular (heart problems, chest pain, irregular heart beat)	yes <input type="checkbox"/>	no <input type="checkbox"/>	
7. Respiratory (asthma, shortness of breath, wheezing, coughing)	yes <input type="checkbox"/>	no <input type="checkbox"/>	
8. Gastrointestinal (heartburn, abdominal pain, diarrhea, vomiting)	yes <input type="checkbox"/>	no <input type="checkbox"/>	
9. Genitourinary (urinary problems, blood in urine)	yes <input type="checkbox"/>	no <input type="checkbox"/>	
10. Integumentary (skin rashes, excessive dryness)	yes <input type="checkbox"/>	no <input type="checkbox"/>	
11. Musculoskeletal (muscle aches, joint pain, swollen joints)	yes <input type="checkbox"/>	no <input type="checkbox"/>	
12. Neurological (numbness, weakness, headaches, paralysis)	yes <input type="checkbox"/>	no <input type="checkbox"/>	
13. Hematologic / Lymphatic (blood disorders, leukemia)	yes <input type="checkbox"/>	no <input type="checkbox"/>	
14. Allergic / Immunologic (hay fever, allergies)	yes <input type="checkbox"/>	no <input type="checkbox"/>	
15. Endocrine (thyroid problems, diabetes)	yes <input type="checkbox"/>	no <input type="checkbox"/>	
16. Psychiatric (depression, anxiety)	yes <input type="checkbox"/>	no <input type="checkbox"/>	

Family and social history: Do any medical or eye diseases run in your family? If YES, please note the relationship to you.

- Glaucoma _____
- Diabetes _____
- High blood pressure _____
- Macular degeneration _____
- Other _____

Do you smoke? If YES, how much?

Drink alcohol? If YES, how much?

Comments: _____

Physician signature _____ Date _____



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FINANCIAL POLICY AND PATIENT AGREEMENT

This is the financial policy of Holly D. Kent, M.D., P.C., dba Colorado Corneal Surgeons (Practice), which we require to be read and signed prior to treatment:

Payment is due at the time of service. Acceptable forms of payment are cash, check, VISA, MasterCard and American Express. Payment not made at time of service is considered past due when the patient leaves the facility. Responsibility for payment for services to dependent children rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals.

Regarding insurance, the patient must recognize that he or she is responsible to pay the full amount for all services unless the Practice has an agreement with the patient's insurance carrier for alternative payments. As a courtesy to patients, the Practice will file insurance claims with all standard insurance carriers. The patient is responsible to make available to the Practice complete insurance information, for accurate filing of claims. Insurance information includes referrals from other providers for primary and secondary insurance coverage, all identification and benefits cards/documents. The patient agrees that if the insurance company denies benefits for any reason or if payment is not received from the insurance carrier within 45 days of the submission of a claim, the patient is responsible for the full amount of the bill immediately.

The Practice's policy on accepting insurance payments varies based on the type of insurance as follows:

- **Indemnity-type Insurance** – Insurance payments received by the Practice will be applied to the patient's account and the patient agrees to pay the balance. We will estimate the patient-responsible portion of the bill at the time of service, and payment of that amount is expected at the time of service. Co-Payments are due at the time of service and are collected before service is provided.
- **HMOs and PPOs** – If the Practice has an agreement with the patient's insurance carrier, we will accept payment from the carrier for services covered by the patient's benefit plan. Co-Payments are due at the time of service and are collected before service is provided. If the practice has to bill you for your co-payment, there will be an additional \$20 charge. For services not covered by the patient's benefit plan, payment is due at the time of service.
- **MEDICARE** – The Practice accepts assignment from Medicare. Therefore, the patient agrees to pay the Practice 20% of the Medicare allowable amount for services plus any amount of the patient's deductible that is not yet paid and any service not covered by Medicare.

By the agreement, the patient also authorizes the exchange of information relating to care and claims with the patient's insurance company(s), and authorizes insurance payments to be made directly to the Practice for services provided under the patient's insurance agreement and otherwise payable to the patient.

The patient hereby acknowledges and agrees that any account that becomes delinquent will be subject to collections service. Patient agrees to pay all court costs and reasonable attorney fees for collection of all past due amounts owed, plus interest thereon at 18% (eighteen per cent) per annum on all such amounts outstanding.

PATIENT AGREEMENT: I have read and understand the financial policy above and agree to the terms stated.

Patient's Printed Name

Patient or Legal Guardian's Signature

Date