Miramar
EYE INSTITUTE

Surgery and Diseases of the Eye **Kenneth O. Karp, M.D.**

PATIENT INFORMATION (información del paciente)

DATE: ____________________ SOCIAL SECURITY #:________-_________- ________ BIRTHDATE: ______-______-______
(fecha) (no. seguro social) (fecha de nacimiento)
LAST NAME________________________________FIRST NAME:______________________________M.I._______________
(apellido) (nombre) (inicial del 2do nombre)
ADDRESS:____
(dirección) STREET NAME (calle) APT. (apto.) CITY (ciudad) STATE (estado) ZIP (código postal)
PHONE #: (________)___________ - _________________________ AGE:_______________ ❑ MALE (hombre) ❑ FEMALE (damas)
(teléfono) (edad)
CELLULAR PHONE: __________________________________ E-MAIL____
IN CASE OF EMERGENCY, PLEASE CONTACT _________________________________ PHONE #___________________________
(en caso de emergencia, Llame a) (número de teléfono)
OCCUPATION:____EMPLOYER PHONE #:__________________________________
(ocupación) (telélono del empleador)
WHO IS YOUR EYE DOCTOR?___________________________ WHO IS YOUR FAMILY DOCTOR? __________________________
(quién es su oculista) (quién es su doctor general)
NAME OF INSURANCE COMPANY: (nombre de la compañía seguro) ____

DO YOU HAVE? (Usted tiene)

HISTORY (historia)

____HIGH BLOOD PRESSURE (presión alta)
____ DIABETES (diabetes)
____ ASTHMA/SHORTNESS OF BREATH (asma) (dificultad al respirar)
____ HEART DISEASE / ATTACK (problemas cardíacos)
____ STROKE (derrame cerebral)
____ STOMACH PROBLEMS (problemas estomacales)
____ARTHRITIS (artritis)
____ HIV (sida)
____ FEVER/ WEIGHT LOSS (fiebre - pérdida de peso)
____ CANCER (cáncer)
____ KIDNEY DISEASE (problemas de riñones)
____ GLAUCOMA
____ LIVER DISEASE (hepatitis)
____ OTHER/ OTRO

HAVE YOU EVER SMOKED? HOW MUCH?
(alguna vez ha fumado) (cuánto) ______________________________

HAVE YOU EVER USED ILLICIT DRUGS? ___ YES (sí) ____ NO (no)
(alguna vez a usado narcóticos sin receta)

HAVE YOU HAD SURGERY ON THE **BODY/EYES**?
(ha tenido cirugía)

_______ YES (sí) _______ NO (no)

YES, WHAT TYPE (si la respuesta es sí, qué tipo)_____________
____
____

LIST ALL MEDICINES YOU ARE TAKING: (Including eye drops)
(escriban todas las pastillas y colirios que esten tomando)
____
____
____
____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? WHICH ONES? (Usted tiene alguna alergia a algún medicamento) (qué tipo)

_______ YES (sí) _______ NO (no)
____
____

IS THERE A FAMILY HISTORY OF: (historia de problemas en los ojos en la familia)

_____ GLAUCOMA? ______ RETINAL DISEASE? (enfermedad de la retina)_________BLINDNESS? (ceguera) REVIEWED by___,____,____

AUTHORIZATION TO PAY /FOR MEDICARE, LIFETIME AUTHORIZATION

I authorize any holder of medical or other information about me to release to my insurance company, and, for Medicare/Blue Cross/Blue Shield to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers or to the billing agent of Blue Cross/Blue Shield of Florida, any information needed for this or a related insurance or claim. I permit a copy of this authorization to be used in place of the original. I further authorize payment of medical and/ or surgical insurance benefits, otherwise payable to me, to the party who accepts assignment. I understand that I am financially responsible for those charges not paid by my insurance.

____ ____
PATIENT SIGNATURE DATE OTHER SIGNATURE/REASON, IF PATIENT IS UNABLE TO SIGN DATE