Irving Eyecare
Bradley M. Kardatzke, O.D.
708 N. MacArthur Blvd
Irving, TX 75061
(972)254-0033

Consent and Acknowledgement Form
Health Information and Patient Information Package

The following items are insurance and governmentally mandated forms, as well as, industry and practice guidelines that directly affect you as a patient and a consumer. These items are important PLEASE READ THEM THOROUGHTLY. By signing below, you provide consent to all forms, as illustrated below and acknowledge receipt of the patient information package. You may revoke any or all of this consent at any time, except the treatment, payment, and operations provisions and unless we have relied upon you consent, but it must be in writing. If you have any questions please do not hesitate to ask the doctor or the staff.

1. Health Insurance Portability and Accountability Act
   A. Consent to Use or Disclose Health Information for Treatment, Payment and Operations. "signature on file"
   B. Authorization for Release of Identifying Health Information. "signature on file"
2. Services for Bradley Kardatzke, O.D. and Associates. "signature on file"
3. Insurance Forms. "signature on file"
4. Medical Device Recommendations. "signature on file"
5. Dilation Recommendation and Consent Form. "signature on file"
6. Patient Record of Disclosure Form. "signature on file"
7. Medicare Advance Beneficiary Notice (ABN), Medicaid, Medicaid Vision Eyeglass Patient Certification Form and/or any private insurance financial notice forms. "signature on file"
8. Assignment of Insurance Benefits: (1) group and individual assignment of benefits (2) Medicare, claim authorization and payment request. "signature on file"
9. Standards for Medical Devices Form. "signature on file"

Patient Name:______________________________________ SS#_____________________

Address:____

City, State, Zip:____

Home Phone:________________________________Cell:__________________________

Work:________________________________ E-mail:______________________________

Signature:___________________________________ Date:__________________________
(patient, parent, guardian)

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Patient Information

Last Name:____________________________First Name:______________________M.I._________

Date of Birth:__________________________Age:_________Sex: M F

Marital Status: Single Married Widowed Divorced

Patient's Occupation:________________________________Last Eye Exam:____________yrs

Please answer all that apply:

List current medications (including over-the-counter, vitamins, herbs) you are taking:

____

____

____

List medication(s) you are allergic to:____

Are you currently under the care of a physician for any of the following:

Diabetes	Y	N	Diabetic Retinopathy	Y	N
High Blood Pressure	Y	N	Glaucoma	Y	N
Thyroid	Y	N	Macular Degeneration	Y	N
Cancer	Y	N	Cataracts	Y	N
Pregnancy	Y	N	Other:__________________________________		

Do you use: Tobacco Y N Alcohol Y N

Family History: Is there any family (blood relative) history of the following:

Diabetes	Y	N
High Blood Pressure	Y	N
Thyroid	Y	N
Cancer	Y	N
Glaucoma	Y	N
Macular Degeneration	Y	N
Cataract	Y	N