SEDALIA EYE ASSOCIATES, P.C.

Kevin R. Skelsey, M.D.
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NAME (last)_____(first)_____ (M.I.)_____ TODAY'S DATE_____

STREET ADDRESS_____ CITY_____ State_____ ZIP_____

SS#_____ GENDER_____ BIRTHDATE_____ AGE_____

MARITAL STATUS: M S W D SPOUSE'S NAME_____

HOW DID YOU HEAR ABOUT OUR OFFICE? ☐ physician referral_____

☐ word-of-mouth referral ☐ phone book ☐ online

HOME PHONE ( )_____ CELL PHONE ( )_____ WORK PHONE ( )_____

EMAIL_____ PLACE OF EMPLOYMENT_____

Would you like access to a Patient Portal where you can view your eyecare history with our office?

If so, an email with a link and login information will be sent to you.

☐ yes, my email is _____ ☐ no, not interested at this time

For future appointment reminders and recall notifications, my preferred method of communication is:

☐ PHONE/VOICE ☐ TEXT (text **sedaliaeye** to **622622** to opt-in)

EMERGENCY CONTACT NAME_____

HOW RELATED_____ CONTACT PHONE #_____

FAMILY PHYSICIAN_____ OPTOMETRIST_____

IF PATIENT IS UNDER 18 YEARS OF AGE AND LIVING WITH PARENTS:

MOTHER'S NAME_____ BIRTHDATE_____ SS#_____

PLACE OF EMPLOYMENT_____ WORK PHONE ( ) _____

FATHER'S NAME_____ BIRTHDATE_____ SS#_____

PLACE OF EMPLOYMENT_____ WORK PHONE ( ) _____

I authorize the physicians at Sedalia Eye Associates to treat _____ (child's name).

Parent or Legal Guardian's Signature_____

INSURANCE INFORMATION

PLEASE CHECK METHOD OF PAYMENT FOR DEDUCTIBLE OR CO-PAYMENT:

☐ CASH ☐ CHECK ☐ VISA / MASTERCARD / DISCOVER ☐ CARE CREDIT

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY?_____