Welcome to our office!

Please fill out this form as completely as possible and return it to the desk.

Name of Doctor you wish to see: | Today's Date

Name | Email Address

Address | Home Phone

Apt.# | ☐ Male ☐ Female | Cell Phone

City | State | Zip Code | Work Phone

Date of Birth | SSN | Fax Phone

Primary Care Physician | Phone

Previous Eye Doctor | Phone

Last Eye Exam | Referred By

Vision Insurance Information

Insurance | Card Number or I.D.#

Cardholder | Group Number

Address | Apt.#

City | State | Zip Code | Date of Birth

Relationship to Insured: ☐ Child ☐ Spouse ☐ Other

Medical Insurance Information

Insurance | Card Number or I.D.#

Cardholder | Group Number

Address: | Apt.#

City | State | Zip Code | Date of Birth

Relationship to Insured: ☐ Child ☐ Spouse ☐ Other

Employer | Sports/Hobbies

Occupation | Emergency Contact | Phone

☐ I wear Glasses ☐ I wear contact lenses ☐ Soft ☐ Hard What brand of contact lens do you currently wear?

Are the contact lenses you are currently wearing comfortable? ☐ Yes ☐ No

Medical History

Allergies

Occular History

Medications

Injuries/ Surgeries

Family Medical History: Note relation to yourself in the box (example: "Mother", "Paternal Grandfather" etc.)

☐ Blindness		☐ Cancer	
☐ Cataracts		☐ Diabetes	
☐ Macular Degeneration		☐ Heart Disease	
☐ Glaucoma		☐ High Blood Pressure	
☐ Retinal Detatchment		☐ Kidney Disease	
☐ Crossed Eyes		☐ Arthritis	
☐ Lupus		☐ Thyroid Disease	

Other:

☐ Currently pregnant or nursing.

☐ Doesn't Drive ☐ Drives ☐ Doesn't Use Tobacco ☐ Uses Tobacco

Driving Difficulties

Type/Amount/How Long?

☐ Doesn't Drink Alcohol ☐ Drinks Alcohol ☐ Doesn't Use Illegal Drugs ☐ Uses Illegal Drugs

Type/Amt/HowLong

Type/Amt/HowLong

Have you ever been exposed to or infected with ☐ Gonhorrhea ☐ Hepatitis ☐ Syphilis ☐ HIV

Review of Systems. Please check all that apply to you.

Eyes

- ☐ Vision Loss
- ☐ Blurry Vision
- ☐ Distorted Vision
- ☐ Double Vision
- ☐ Dryness
- ☐ Redness
- ☐ Mucous Discharge
- ☐ Gritty Feeling
- ☐ Itching
- ☐ Burning
- ☐ Excess Watering
- ☐ Light Sensitivity
- ☐ Eye Pain/Soreness
- ☐ Chronic Infection
- ☐ Sties
- ☐ Flashes
- ☐ Floating Spots
- ☐ Tired Eyes
- ☐ Cataracts
- ☐ Diabetic Retinopathy
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detatchment

Gastrointestinal

- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Ulcers
- ☐ Constipation
- ☐ Diarrhea

Constitutional

- ☐ Fever
- ☐ Weight Loss/Gain
- ☐ Fatigue
- ☐ Trauma

Integumentary (Skin)

- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis

Neurologic

- ☐ Headaches
- ☐ Migraines
- ☐ Seizures
- ☐ Mult. Sclerosis

Endochrine

- ☐ Non Insulin Diabetes
- ☐ Insulin Diabetes
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction

Respiratory

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema

Cardiovascular

- ☐ Heart Disease
- ☐ Hypertension
- ☐ Hypercholesterolemia

Ears/Nose/Throat

- ☐ Allergies
- ☐ Sinus Congestion
- ☐ Runny Nose
- ☐ Post Nasal Drip
- ☐ Chronic Cough
- ☐ Dry Throat/Mouth

Allergic/Immune

- ☐ Drug Allergies
- ☐ Seasonal Allergies
- ☐ Lupus
- ☐ Arthritis

Lymphatic/Hematologic

- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Leukemia

Musculoskeletal

- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Ankylosing Spond.

Genitourinary

- ☐ Kidney Problems
- ☐ Bladder Problems
- ☐ STD's

Please list any other symptoms you may be experiencing.

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please read it carefully. The privacy of your health information is important to us.

Our Legal Duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We will use and communicate your health information only for the purpose of providing your treatment, obtaining payments and conducting health care operations.

USES AND DISCLOSURES OF HEALTHCARE INFORMATION:

To Provide Treatment: We will use and disclose your health information within our office to provide you with the best health care possible. This may include business office staff, assistants, opticians, physician assistants, nurses, and physicians. In addition, we may share our health information with referring physicians, laboratories, pharmacies, and other health care personnel providing you treatment, including contact lens and frame companies.

To Obtain Payment: We may use and disclose your health information to obtain payment for services, materials, and treatment you received in our office. We may do this with insurance forms filed for you by mail or send electronically.

Healthcare Operations: Your health information may be used during performance evaluation of our staff, training programs for students, interns, associates, and business and/or clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing or credentialing activities.

Appointment Reminders: Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time to contact us for an appointment. Additionally, we may contact you for follow up on your care and inform you of treatment options or services that may interest you or a family member. These may include postcards, folding cards, letters, telephone, voice mail, or email.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we believe a patient is a victim of abuse, neglect or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Public Health and National Security: We may disclose to Federal Officials or military authorities your health information required for lawful intelligence, counterintelligence, and other national security activities.

Law Enforcement: As permitted or required by State or Federal Law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends, and Caregivers: We may disclose your health information to a family member, friends, care giver, or other person who you tell us will be helping you with your home hygiene, treatment, medications, or payment. In case of an emergency, where you are unable to tell us what you want we will use our very professional judgment when sharing your health information. We will also use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, materials, or other similar forms of health information.

To Coroners, Funeral Directors, and Medical Examiners: We may be required by law to provide information about your health to coroners, funeral directors, and medical examiners for the purpose of determining a cause of death and preparing for a funeral.

Required by Law: We may use or disclose your health information when required to do so by law.

Your Authorization: Other than stated above or where Federal, State or Local Law requires us, we will not disclose your health information without your written authorization. You may revoke your authorization in writing at any time. Your revocation will not effect any use of disclosures permitted by your authorization while it was in effect.

PATIENT RIGHTS:

Access: You have the right to look or get copies of your health information, with limited exceptions (you must make a request in writing to obtain access to your health information). If you request copies, we will charge you a fee for each page, and per hour for staff time to locate, duplicate and assemble your copy, and postage if you request the copies to be mailed to you.

Documentation of Health Information: You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health care operations and certain other activities. Our documentation procedures will enable us to provide information form April 14, 2002 and forward. Please let us know in writing the time period for which you are interested. Your request must be limited to no more than six years at a time. We may charge you a reasonable fee for your request.

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative location. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location. We will make every effort to honor your reasonable request for confidential communications.

Amendments: You have the right to ask us to amend your health information. In order to standardize our process, please submit your request in writing and describe the reason for the change. Your request may be denied under certain circumstances.

Request a Paper Copy of this Notice: You have the right to obtain a copy of this Notice of Privacy Practices from our office at any time.

Complaints: If you think that we have not properly respected the Privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office of Civil Rights. We support your right to the privacy of your health information. If you want more information please contact our office.

Acknowledgement of Receipt of Notice of Privacy Practices

I, the patient, have received a copy of this office's Notice of Privacy Practices.

Print Name _____

Sign Name _____

Date

Financial Responsibility

To our patients with Medical and/or Vision benefits:
We will be happy to file your insurance claim forms or take assignment on your medical/vision benefits as designated by the:

Plan(s) of which you state you are a member. We will do all we can to help you receive maximum benefits. However, in the event that the plan sponsor determines that you are not eligible for coverage at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by you and not paid by the plan sponsor.

Print Name _____

Sign Name _____

Date