# PATIENT INFORMATION

Today's Date:_____

Patient Name: _____ Date of Birth: _____

Age: _____ Name you like to be called: _____ How may we contact you? Mail Phone E-Mail

Gender: M _____ F _____ Race (circle one): American Indian African American Asian Native Hawaiian White

Ethnicity: Not Hispanic or Latino: _____ Hispanic or Latino: _____ Primary Language: _____

Address:_____

City:_____ State:_____ ZIP:_____

e-mail: _____ Social Security#:_____

Telephone # : Home: _____ Work:_____ Cell:_____

Occupation: _____ Employer:_____

Emergency Contact: _____ Phone # _____ Relationship:_____

Hobbies: _____Whom may we thank for referring you?_____

Is Patient Under 18 Years Old? Yes ____ No _____, if yes complete the following:

Parent or Legal Guardian:_____ Relationship: _____

Address (if different from patient)_____

City:_____ State:_____ ZIP _____

## Insurance Information:

Insured Name: _____ Relationship to patient? _____

Insured Social Security # (if different from above): _____ Insured Date Of Birth: _____

Primary Medical Insurance Company: _____ ID#_____ Group # _____

Secondary Medical Insurance Company: _____ ID# _____ Group# _____

Vision Care Plan: _____

Assignment and Release:
I certify that I, and/or my dependants, have insurance coverage with _____ and assign directly to Dr. O'Hara/ Dr. Fine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions.
The above named practice may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

_____ _____
Signature of Patient, Parent, Guardian, or Legal Representative Please Print Name

_____ _____
Date Relationship to Patient

# MEDICAL HISTORY QUESTIONNAIRE

Today's Date: _____

Name: _____ Date of Birth: _____

## Review of Systems:

Height: _____ inches Weight: _____ pounds

**Do you PRESENTLY have any problems in the following areas? If yes please give an explanation.**

| | YES | NO | Explanation of Problem |
|---|---|---|---|
| **EYES** | | | |
| Loss or blurred vision | [ ] | [ ] | _____ |
| Double Vision | [ ] | [ ] | _____ |
| Itching, burning, or discharge | [ ] | [ ] | _____ |
| Redness | [ ] | [ ] | _____ |
| Scratchy feeling, dryness, or tearing | [ ] | [ ] | _____ |
| Glare/light sensitivity | [ ] | [ ] | _____ |
| Eye Pain/ Soreness | [ ] | [ ] | _____ |
| Flashes of light | [ ] | [ ] | _____ |
| Floaters or spots in vision | [ ] | [ ] | _____ |
| **CONSTITUTIONAL SYMPTOMS** | | | |
| Recent fever, recent weight loss or gain | [ ] | [ ] | _____ |
| **SKIN** | | | |
| Recent rashes, nodules, inflammation, Eczema | [ ] | [ ] | _____ |
| **EAR, NOSE, MOUTH, THROAT** | | | |
| Recent Colds, Upper Respiratory Infection | [ ] | [ ] | _____ |
| Sinus congestion or infection | | | |
| **CARDIOVASCULAR** | | | |
| High blood pressure, heart disease, high cholesterol, A Fib | [ ] | [ ] | _____ |
| **RESPIRATORY** | | | |
| Asthma, emphysema, tuberculosis | [ ] | [ ] | _____ |
| **GASTROINTESTINAL** | | | |
| Crohns Disease, Ulcers, etc. | [ ] | [ ] | _____ |
| **GENITOURINARY** | | | |
| Kidney disease, prostate disease, urethritis | [ ] | [ ] | _____ |
| **MUSCULOSKELATAL** | | | |
| Recent joint or muscle pain | [ ] | [ ] | _____ |
| **NEUROLOGICAL** | | | |
| Stroke, Paralysis, Headaches, Migraines | [ ] | [ ] | _____ |
| **PSYCHIATRIC** | | | |
| Depression, Anxiety, etc. | [ ] | [ ] | _____ |
| **ENDOCRINE** | | | |
| Thyroid disease, Diabetes, etc | [ ] | [ ] | _____ |
| **HEMATOLOGIC/ LYMPHATIC** | | | |
| Blood Disorders, Lymphatic Disease | [ ] | [ ] | _____ |
| **ALLERGY/ IMMUNOLOGIC** | | | |
| Hay Fever, immunological diseases | [ ] | [ ] | _____ |

## PAST EYE HISTORY

Date of Last Eye Exam: _____ Name of your last eye doctor? _____

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| History of cataracts | [ ] | [ ] | History of glaucoma | [ ] | [ ] | Eye Injury | [ ] | [ ] |
| Eye Surgery | [ ] | [ ] | Lazy or crossed eyes | [ ] | [ ] | Macular Degeneration | [ ] | [ ] |
| Dry Eye | [ ] | [ ] | Retinal Problem | [ ] | [ ] | | | |

Eye Drops Currently Used: _____ List any allergies to eye drops: _____

_____ _____

**PLEASE TURN OVER**

## VISUAL HISTORY

Do you wear contact lenses? **Yes** [ ] **No** [ ] How many hours per day? _____ What solution do you use? _____

What type of contact do you use? ( circle) soft gas permeable Do you sleep with your lenses? _____

How often do you change your lenses? ( circle) Daily 2 week monthly quarterly yearly other_____

Do you currently wear glasses? **Yes** [ ] **No** [ ] if yes, when? All the time ___ Driving ____ Computer ____ Reading ____

## PAST MEDICAL HISTORY

Family Doctor's Name: _____ Date of Last Physical Exam: _____

List all major illnesses: Diabetes **Yes** [ ] **No** [ ] how long? _____ Hypertension **Yes** [ ] **No** [ ] Heart Disease **Yes** [ ] **No** [ ]

List All Medical Conditions: _____

_____

_____

List the medications with dosage amounts that you are currently using:_____

_____

_____

List any major surgical procedures: _____

_____

Please list any allergies to medications? _____

_____

## FAMILY HISTORY

| EYES: | Yes | No | Relationship | MEDICAL: | Yes | No | Relationship |
|---|---|---|---|---|---|---|---|
| Cataracts | [ ] | [ ] | _____ | Diabetes | [ ] | [ ] | _____ |
| Glaucoma | [ ] | [ ] | _____ | Hypertension | [ ] | [ ] | _____ |
| Macular Degeneration | [ ] | [ ] | _____ | Heart Disease | [ ] | [ ] | _____ |
| Retinal Detachment | [ ] | [ ] | _____ | High Cholesterol | [ ] | [ ] | _____ |
| Blindness | [ ] | [ ] | _____ | Heart Disease | [ ] | [ ] | _____ |
| Amblyopia (Lazy Eye) | [ ] | [ ] | _____ | Arthritis | [ ] | [ ] | _____ |
| Strabismus (Eye turn) | [ ] | [ ] | _____ | Endocrine Disease | [ ] | [ ] | _____ |
| | | | | Cancer | [ ] | [ ] | _____ |

## SOCIAL HISTORY

| | | | |
|---|---|---|---|
| Do you drink alcohol? | [ ] | [ ] | Frequency ? _____ |
| Do you smoke? | [ ] | [ ] | How many packs per day? _____ |
| Are you chew tobacco? | [ ] | [ ] | How much? _____ |
| Do you use street drugs? | [ ] | [ ] | |
| Do you exercise? | [ ] | [ ] | How often? _____ |
| Are you pregnant? | [ ] | [ ] | How many months? _____ |
| Are you nursing? | [ ] | [ ] | |

Doctor's Signature: _____ Date: _____

# NOTICE OF PRIVACY PRACTICES

Effective 4/14/2003

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

## TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" means those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

**We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask for your special written permission.**

## APPOINTMENT REMINDERS

We may also communicate with you by sending your postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell use that you do not want to receive these communications). These communications are used to remind you of scheduled appointments, or that it is time to schedule a routine appointment and to notify you of other treatments or services available at our office that might help or be of interest to you.

## ABUSE OR NEGLECT

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

## PUBLIC HEALTH AND NATIONAL SECURITY

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or to national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

## FOR LAW ENFORCEMENT

We may make disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else.

## TO CORONERS, FUNERAL DIRECTORS AND MEDICAL EXAMINERS

We may make disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ tissue donations.

## MEDICAL RESEARCH

Disclosures for health related research would happen only under the ethical guidance, requirements, and approval of an Institutional Review Board.

## AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, or where Federal, State or Local law requires us, we will not make any other disclosures of your health information unless you sign a written "authorization form." You may revoke that authorization at any time, unless we have already acted in reliance upon it. Revocations must be in writing.

## YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information

### RESTRICTIONS/ CONFIDENTIAL COMMUNICATIONS

You may ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.

You may ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using email to your personal email address. We will accommodate these requests if they are reasonable. If you want to ask for confidential communications, send a written request to the office.

### YOUR RIGHTS TO YOUR HEALTH INFORMATION

You have the right to ask us to amend or update your health information if you think that it is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us your request in writing and describe your reason for the change. Your request may be denied if the health information record in questions was not created by our office, is not part of our records, or if the records containing your health information are determined to be accurate and complete.

You have the right to read, review and copy your health information, including your complete chart, and billing records within 30 days of asking us (or sixty days if the information is stored off-site). If you want to review or get photocopies of your health information, send a written request. We may need to charge you a reasonable fee to duplicate and assemble your copy.

You may ask us for a list within the past six years (or a shorter period if your want) of the disclosures that we have made of your health information for any reason other than disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. We may need to charge you a reasonable fee for your request.

### REQUEST ADDITIONAL COPIES OF THIS NOTICE

If you want additional paper copies, send a written request to the office.

### OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office and have copies available in our office.

### COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to use or to the US Department of Health and Human Services. We encourage you to let us know any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

### THANK YOU

Thank you for taking the time to review how we are using your health information. If you have any questions, please feel free to ask. If not, we would appreciate your acknowledging your receipt of our policy by signing below.

### ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Stephen Fine, Dr. Mary O'Hara and Park Opticians Notice of Privacy Practices.

Patient Name: _____ Date: _____

Signature: _____