PATIENT INFORMATION

Last Name:_____ First Name:_____ MI:_____ Suffix:_____

Home Phone: _(_____)_____ Work: _(_____)_____ Cell:_(_____)_____

Preferred Contact#: ☐ Home ☐ Work ☐ Cell Marital Status: ☐Sing ☐Mar ☐Div ☐Wid ☐Sep

SSN:_____ DOB:_____ Sex: ☐ M ☐ F

Preferred Language: ☐ English ☐ Spanish ☐ Other_____

Street Address/City/State/Zip:_____

Billing Address:_____

Email Address:_____ Employer/Occupation:_____

Full Time Resident? ☐ Y ☐ N If No, Other Address:_____

Primary Care Physician:_____ Address:_____

Who Can We Thank For Referring You To Our Practice:

☐ Eye Doctor:_____ ☐ Other Doctor:_____

☐ Family/Friend ☐ Insurance ☐ Employer ☐ Website ☐ TV ☐ Magazine ☐ Newspaper ☐ Internet ☐ Billboard

☐ Yellow Pages ☐ Seminar/Health Fair ☐ Other_____

GUARANTOR OR RESPONSIBLE PARTY: ☐ Self (Patient) ☐ Other (If Patient Is Minor)

If Other, Last Name:_____ First Name:_____ MI:_____ Suffix:_____

Home Phone: _(_____)_____ Work: _(_____)_____ Cell:_(_____)_____

DOB:_____ Relationship To Patient:_____

EMERGENCY CONTACT (Other than telephone number listed above)

Name:_____ Relationship To Patient:_____

Home Phone: _(_____)_____ Work: _(_____)_____ Cell:_(_____)_____

X_____ _____ X_____ _____

Patient Signature Date Parent or Guardian Signature Date

PATIENT MEDICAL HISTORY

DATE:_____

Please check YES or NO if you have or ever had any of the following:

☐ Y	☐ N	Cancer - Type_____	☐ Y	☐ N	High Cholesterol
☐ Y	☐ N	Taken Flomax / Hytrin / Cardura	☐ Y	☐ N	Thyroid Disease
☐ Y	☐ N	High Blood Pressure	☐ Y	☐ N	Diabetes – ☐Oral ☐Diet ☐Insulin
☐ Y	☐ N	Stroke / CVA	☐ Y	☐ N	GERD
☐ Y	☐ N	Heart Disease / Murmur	☐ Y	☐ N	Kidney Disease
☐ Y	☐ N	Heart Attack	☐ Y	☐ N	Kidney Stones
☐ Y	☐ N	Congestive Heart Failure	☐ Y	☐ N	Liver Disease
☐ Y	☐ N	Irregular Heartbeat / Palpitations	☐ Y	☐ N	Hepatitis – ☐A ☐B ☐C
☐ Y	☐ N	Asthma	☐ Y	☐ N	Auto-Immune Disease – Type_____
☐ Y	☐ N	COPD	☐ Y	☐ N	Infectious Diseases_____
☐ Y	☐ N	Migraines	☐ Y	☐ N	Dementia / Memory Loss
☐ Y	☐ N	Arthritis	☐ Y	☐ N	MRSA
☐ Y	☐ N	Sleep Apnea - Use a CPAP? ☐Y ☐N			

Have you received a pneumonia vaccine? ☐ Y ☐ N

Have you ever smoked? ☐ Y ☐ N - Do you still smoke? ☐ Y ☐ N

Do you drink alcohol? ☐ Y ☐ N - ☐Daily ☐Occasionally ☐Rarely

SURGERIES

Please check the box if you have had any of the surgeries listed below:

☐ Bypass	☐ Hip Replacement	☐ No Surgical Procedures	☐ Cataract Surgery
☐ Pacemaker	☐ Prostate	☐ Thyroidectomy	☐ LASIK / RK
☐ Heart Stents	☐ Colostomy	☐ Appendectomy	☐ Retinal Detachment
☐ Knee Replacement	☐ Mastectomy	☐ Gallbladder	☐ Cornea Transplant
		☐ Back Surgery	☐ Glaucoma Procedure
			☐ Eyelid Procedure

OTHER EYE DIAGNOSIS

Have you been diagnosed with any of the following eye diseases/disorders:

☐ Cataracts	☐ Diabetic Retinopathy	☐ Other_____
☐ Glaucoma	☐ Corneal Disease	☐ Other_____
☐ Macular Degeneration	☐ Amblyopia / Lazy Eye	☐ Other_____

ALLERGIES

☐ Yes – Please list below ☐ No Known Allergies Latex Allergy? ☐ Yes ☐ No

MEDICATIONS

Please list any medications you take, prescription or over the counter; You may provide a list if available:

FAMILY HISTORY

Do you have any FAMILY history of: (Mother, Father, Siblings, Grandparents)

Diabetes	☐ Y	☐ N	Who:_____
Glaucoma	☐ Y	☐ N	Who:_____
Macular Degeneration	☐ Y	☐ N	Who:_____
Blindness	☐ Y	☐ N	Who:_____
Adopted/Unknown	☐		

X_____ _____ X_____ _____

Patient Signature Date Parent or Guardian Signature Date

REVIEW OF SYSTEMS

DATE:_____

Please check all that apply to your **current** and **past** health.
Boxes that are not checked will be considered a negative response.

General / Constitutional

- ☐ Overall Healthy
- ☐ Weight Loss / Gain
- ☐ Fatigue
- ☐ Fever and Chills
- ☐ Weakness

Integumentary (Skin)

- ☐ Skin Cancer
- ☐ Rash
- ☐ Bruising
- ☐ Suspicious growths
- ☐ Itching

Ears/Nose/Mouth/Throat

- ☐ Dry Mouth
- ☐ Sinus Pain / Infections
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Wears hearing aids

Respiratory

- ☐ COPD
- ☐ Asthma
- ☐ Emphysema
- ☐ Oxygen use
- ☐ Shortness of Breath

Cardiovascular

- ☐ Chest Pain
- ☐ Hypertension
- ☐ Heart attack
- ☐ Heart Surgery
- ☐ Palpitations

Gastrointestinal

- ☐ Heartburn / Acid reflux
- ☐ Diverticulitis
- ☐ Nausea
- ☐ Hernia
- ☐ Ulcers

Musculoskeletal

- ☐ Arthritis
- ☐ Back pain
- ☐ Swelling of joints
- ☐ Stiffness
- ☐ Muscle pain / joint pain

Neurological

- ☐ Memory Loss
- ☐ Headaches
- ☐ Parkinson's disease
- ☐ Seizures
- ☐ Tremors

Endocrine

- ☐ Diabetes
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Frequent Urination
- ☐ Excessive thirst

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Stress

Allergies / Immunological

- ☐ Allergic reaction to medications
- ☐ Allergic reaction to foods
- ☐ Seasonal / Environmental allergies
- ☐ Autoimmune disease

Other conditions or medical problems not listed?:

_____

_____

_____

X_____ _____ X_____ _____

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VISUAL ASSESSMENT FORM AND LIFESTYLE QUESTIONNAIRE

Occupation:_____

Hobbies:_____

In order for our doctors to assist you in making the best possible decision about your vision and hearing needs, please take a moment to complete the front and back of the questionnaire.

Circle the degree of difficulty you have doing the following activities because of your vision.

Functional Vision Assessment	**Circle One**			
Difficulty seeing street signs or driving (curbs, highway exits, traffic lights, halos/glare in lights)	No	Mild	Moderate	Severe
Difficulty seeing under glare (halos,, starburst, tracking golfball in sky, driving in bright Sunlight, oncoming headlights)	No	Mild	Moderate	Severe
Difficulty seeing TV or movies (faces, numbers, printing)	No	Mild	Moderate	Severe
Difficulty reading small print with glasses (books, newspaper, pill bottles, instructions, cell phone)	No	Mild	Moderate	Severe
Difficulty with personal correspondences (writing checks, reading bills, filling out forms)	No	Mild	Moderate	Severe
Difficulty with leisure activities (playing cards, bingo, bowling, golfing)	No	Mild	Moderate	Severe
Difficulty functioning around the house (cooking, general household upkeep, stairs, telephone)	No	Mild	Moderate	Severe
Difficulty recognizing faces of people (church, grocery store, clubs, other daily activities)	No	Mild	Moderate	Severe

Please circle the activities you would prefer to do with less dependence on glasses:

Reading Seeing pill bottles Looking at a menu Looking at your watch Using a cell phone

Card or table games Sewing Applying makeup Using a computer Seeing price tags

View dashboard of car Seeing price tags/shelves Shopping Bingo Driving

Playing sports, like golf Watching TV Watching live sports Going to movies Swimming

X_____ _____ X_____ _____

Patient Signature Date Parent or Guardian Signature Date

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I. My Authorization

I authorize the following using or disclosing party:

_____

to use or disclose the following health information.

☐ - All of my health information

☐ - My health information relating to the following treatment or condition:

_____

☐ - My health information covering the period from _____ (date) to _____ (date)

☐ - Other: _____

The above party may disclose this health information to the following recipient:

Name (or title) and organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

The purpose of this authorization is (check all that apply):

☐ - At my request

☐ - Other: _____

☐ - To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.

☐ - To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.

This authorization ends:

☐ - On (date)_____

☐ - When the following event occurs: _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____

Date: _____

If the patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor: _____ years of age

☐ - Patient is unable to sign because: _____

Signature of Authorized Representative: _____

Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____

III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment.** Separate consent must be given before this information can be released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____

IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment.** Separate consent must be given to have this information released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____