Primary Eye Care

ASSOCIATES

Date:______________

Name____ Email____________________________________
Address ____
Telephone (Home) ____________________________________ (Cell) __________________________________
SSN ____ - ____ - ______ Date of Birth __________________ Marital Status __________ Race___________
Occupation/Employer____
Emergency Contact/Telephone Number ____
Date of last eye exam ____________________ Dilated? Y /N Last Eye Doctor______________________
Health Insurance Provider ________________________Vision Insurance Provider______________________
Primary Insured's Name___________________________ Primary Insured's SSN_______________________
Relationship to Primary Insured ___________________ Primary Insured's Date of Birth ________________

Personal Eye Health Information

Have you had any eye operations? Y / N Type ______________________________Date ________________
Have you had an eye injury? Y / N Kind__________________________________Date ________________
Do you have glaucoma? Y / N Cataracts? Y / N Dry eyes? Y / N Blurred vision? Y / N
Other eye problems? Y / N What kind? ____
Do you wear glasses? Y / N Contact lenses? Y / N Type ____

Medical Information

What is your general health? ____

Do you have problems with any of these systems? *(Please circle all that apply.)*

Gastrointestinal	Y / N	Nervous	Y / N	Mental	Y / N
Ears/Nose/Throat	Y / N	Endocrine (glands)	Y / N	Headaches	Y / N
Cardiovascular	Y / N	Musculoskeletal	Y / N	Blood/Lymph	Y / N
Respiratory	Y / N	Integumentary (skin)	Y / N	Allergic/Immunologic	Y / N

Please explain ____

Please answer all that apply:
Diabetes Y / N Type _______________ Last A1C _______________ Date of Diagnosis ________________
Current medication(s) ____
Medication allergy Y / N Allergic to What? ____
Other Allergies Y / N Allergic to What? ____
Other health problems ____
Have you had any operations? Y/N What kind/When? ____
Do you use cigarettes/tobacco? Y / N Alcohol? Y / N Other substance(s)? Y / N
Name of Primary doctor ______________________________________ Date of last visit __________________

Family History- Has anyone in your family had any of these conditions?

High blood pressure Y / N Macular degeneration Y / N Diabetes Y / N
Retinal detachment Y / N Glaucoma Y / N Cataracts Y / N
Which family members were affected?____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? **YES / NO**

May we leave a detailed message on your answering machine at home or on your cell phone? **YES / NO**

May we discuss your medical condition with any member of your family? **YES / NO**

If YES, please name the members allowed:

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____

This consent was signed by: (PRINT NAME PLEASE) _____________________________________

Patient Signature: ____ Date: ______________

Office Witness: ____Date: ______________

The full Office Policy is posted for me to read in the waiting room & by signing below I agree to this policy.
I also attest that all the information provided on this patient paperwork is accurate and complete.

Patient Signature ____ Date: _______________