HIPAA PRIVACY

Acknowledgment of Receipt of Privacy Notice

By signing this acknowledgment of Receipt of Notice of Privacy Practices (The "Notice"); I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below.

I understand that the Location may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/ or type of products provided) to another party to permit the Location to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims or medical insurance claims and communicate with me regarding vision care services provided by the Locations (for example, mailings of exam reminders or information about services / products provided by the Location)

I can be assured that this Location does not sell my personal health information of any kind to a third party for such party's own use. I acknowledge and agree that the Location may submit my vision benefit claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received from the Location.

______________________________________ ______________________________

Patient signature or Patient's Legal Representative Date

PATIENT INFORMATION

EXAM DATE ___/___/___/

LAST NAME ____________________ FIRST NAME ____________________ ☐ M ☐ F BIRTHDATE ___/___/___

ADDRESS ____________________ CITY ____________________ STATE ________ ZIP ____________

PREFERRED PHONE ____________ *HOME WORK CELL (CIRCLE ONE)* SECONDARY PHONE ____________ *HOME WORK CELL (CIRCLE ONE)*

We use phone calls to remind patients of their appointments. We will use the phone number you provide and the call may be live or prerecorded.

EMPLOYER ______________________________ OCCUPATION ____________________

REFERRED BY ____________________ EMAIL ____________________ SIGNATURE ____________________

INSURANCE INFORMATION

PLAN NAME ____________________ GROUP ____________________

INSURED NAME ____________________ RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ CHILD *(CHECK ONE)*

INSURED ID# ____________________ INSURED'S DATE OF BIRTH ___/___/___

MEDICAL AND OCULAR HISTORY

WHAT IS THE REASON FOR TODAY'S EXAM? ______________________________

____

PREVIOUS PATIENT ___/___/___ IF NOT, DATE OF LAST EYE EXAM ___/___/___ BY DR. ____________________

ARE YOU PLANNING TO GET NEW GLASSES TODAY? ☐ YES ☐ NO

ARE YOU PLANNING TO GET NEW CONTACT LENSES TODAY? ☐ YES ☐ NO

AGE OF PRESENT GLASSES ____________ AGE OF SUNGLASSES ____________

DO YOU OR ANY OF YOUR BLOOD RELATIVES *(I.E. GRANDPARENTS, BROTHER OR SISTER)* HAVE ANY OF THESE CONDITIONS?

	SELF	RELATIVE	NONE
DIABETES	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐
THYROID PROBLEMS	☐	☐	☐
HEART DISEASE	☐	☐	☐
ASTHMA	☐	☐	☐
CANCER	☐	☐	☐

	SELF	RELATIVE	NONE
GLAUCOMA	☐	☐	☐
CATARACTS	☐	☐	☐
RETINAL DISEASE	☐	☐	☐
EYE SURGERY	☐	☐	☐
EYE INJURY	☐	☐	☐
OTHER ____________	☐	☐	☐

	YES	NO
DO YOU SEE DOUBLE	☐	☐
FREQUENT HEADACHES	☐	☐
ARE YOU PREGNANT?	☐	☐
EYES BEEN DILATED?	☐	☐ YEAR? ________
PRIMARY CARE DR.		

PLEASE EXPLAIN ANY POSITIVE FINDINGS: ______________________________

____

ARE YOU TAKING ANY EYEDROPS (PRESCRIPTION OR OVER THE COUNTER}? PLEASE LIST. ____________

____

ARE YOU TAKING ANY OTHER MEDICATIONS (PRESCRIPTION OR OVER THE C0UNTER)? PLEASE LIST. ____________

____

DO YOU HAVE ANY ALLERGIES, MEDICATION OR OTHER? IF YES, PLEASE EXPLAIN. ____________

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PROCEED TO CONSULTATIVE Rx FORM