Patient's Name _____ **Today's Date** _____

How did you hear about our office? (Referred by):

Demographics

Preferred Language
- ☐ English
- ☐ Other (Please indicate which): _____

Race
- ☐ Other
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Spouse, Dependent(s), or Guarantor(s)

Please include date of birth, and their relationship to the patient

	Husband	Wife	Child	Sibling	Other (please indicate relationship)

Financial Responsibility

We will be happy to file the insurance claim forms for the medical/vision plan(s) which you state you are a member. If your plan determines that you are not eligible for coverage, have not met your deductible, 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**. If an overpayment has been determined by your plan, you will be refunded (amounts less than $10 will be credited to your account unless a refund is requested).

Signature: _____

Acknowledgement of Receipt of Notice of Privacy Practices

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

Signature: _____

Communication Consent

If you would like to authorize us to discuss your medical information with anyone (spouse, family members, etc…) please list their full names, relationship, and sign below

	Husband	Wife	Child	Sibling	Other (please indicate relationship)

Signature: _____

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Patient's Name		Today's Date	

BOXES WHICH ARE NOT MARKED FOR ANY OCULAR AND MEDICAL CONDITIONS ARE CONSIDERED NEGATIVE

REASONS FOR YOUR EXAMINATION
(Please check one box)

The main reason for this examination
- ☐ Returning Patient Visit
- ☐ New Patient Visit
- ☐ Special Eye Problem Evaluation
- ☐ Follow-up for Problem Evaluation
- ☐ Referral for Special Eye Condition
- ☐ Referral from a Health Care Provider
- ☐ Referral from an Eye Care Provider
- ☐ Referral from School or other Advocate
- ☐ Other:

Date of most recent eye exam (if new patient):

Most recent eye doctor (if new patient):

Individual completing this interview (if not self):

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?

- ☐ Cataracts
- ☐ Age-related Macular Degeneration
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Diabetic Retinopathy
- ☐ Dry Eye
- ☐ Eye infection, inflammation, or allergy
- ☐ Floaters and/or flashes
- ☐ Iritis or Uveitis
- ☐ Retina defects or degenerations

Other:

ARE YOU HAVING ANY OF THE FOLLOWING EYE CONCERNS?

- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Tearing
- ☐ Discharge

Other:

ARE YOU HAVING ANY OF THE FOLLOWING VISION CONCERNS?

- ☐ Blurred vision
- ☐ Eyestrain
- ☐ Eye pain
- ☐ Severe sensitivity to lights
- ☐ Headache
- ☐ Poor night vision
- ☐ Bothersome night glare
- ☐ Double vision
- ☐ Total loss of vision

Other:

DO YOU HAVE ANY OF THE FOLLOWING COMPUTER DEMANDS ON YOUR VISION?

- ☐ Computer use for extended periods
- ☐ Unusual ergonomic demands
- ☐ Must simultaneously view paperwork and computer
- ☐ Use of laptop
- ☐ Use of multiple desktop monitors

Hours of computer use, per day:

Additional computer demands:

For Internal Use Only: ☐ Entered

CONTACT LENSES
(Please check one box)

- ☐ **I am wearing contact lenses right now**
  - ☐ I like my current contact lenses
  - ☐ I want to try a different brand of contact lens
- ☐ **I wear contact lenses but am NOT wearing it right now**
  - ☐ I like the contact lenses I was previously wearing
  - ☐ I want to try a different brand of contact lens
- ☐ **I am interested in contact lenses (previous wearer)**
- ☐ **I am interested in contact lenses (new wearer)**
- ☐ **I am not interested in contact lenses**

PATIENT MEDICAL HISTORY

Constitutional
- ☐ Developmental Disabilities
- ☐ Cancer
- ☐ Fatigue Syndrome

Genitourinary
- ☐ Kidney Disease
- ☐ Prostate Disease / Cancer
- ☐ STD
- ☐ Benign Prostate Hypertrophy
- ☐ Herpes
- ☐ Chlamydia

Ear/Nose/Throat
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis

Musculoskeletal
- ☐ Osteoarthritis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Gout

Neurological
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Stroke / CVA
- ☐ Migraine
- ☐ Autism Spectrum Disorder

Integumentary
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Herpes Simplex / Cold sores
- ☐ Herpes Zoster / Shingles

Psychological
- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder

Endocrine
- ☐ Type 2 Diabetes
- ☐ Type 1 Diabetes
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction

Cardiovascular
- ☐ Hypertension
- ☐ Stroke / CVA
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure

Hematologic / Lymphatic
- ☐ Anemia
- ☐ Large-volume Blood Loss
- ☐ Ulcer
- ☐ Hypercholesteremia

Respiratory
- ☐ Cigarette Smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea

Allergic/Immune
- ☐ Drug allergies
- ☐ Environmental Allergies
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjogren's Syndrome

Gastrointestinal
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease

- ☐ **PREGNANT**
- ☐ **NURSING**

Other

For Internal Use Only: ☐ Entered

Patient's Name		Today's Date	

CURRENT MEDICATIONS
***None unless written below**

CURRENT ALLERGIES
***None unless written below**

PAST OCULAR HISTORY
***Negative unless checked**

☐ Glacuoma suspect	☐ Amblyopia
☐ Glaucoma	☐ Retinal degeneration
☐ Cataract	☐ Retinal hole
☐ Macular degeneration	☐ Retinal detachment
☐ Surgery	☐ Keratoconus
☐ Inflammatory disorder	☐ Injury
☐ Strabismus	☐ Dry Eye
	☐ Nystagmus

Other:

PATIENT SOCIAL HISTORY

☐ Drives ☐ Does not drive

Explain driving difficulties:

☐ Drinks alcohol ☐ Does not drink alcohol

Amount

☐ Uses tobacco ☐ Does not use tobacco

☐ Smokes Cigarettes
☐ Smokes Cigars
☐ Smokes Pipe
☐ Smokes Other
☐ Uses Smokeless Tobacco
Amount

☐ Current every day smoker
☐ Current some day smoker
☐ Former smoker
☐ Heavy tobacco smoker
☐ Light tobacco smoker
☐ Never smoker

HOBBIES

FAMILY HISTORY	***PLEASE PUT AN X FOR EACH FAMILY MEMBER WITH THE LISTED CONDITION***					
☐ None ☐ Unknown	**Father**	**Mother**	**Brother**	**Sister**	**Son**	**Daughter**
☐ Lupus (397856003)						
☐ Cancer (275937001)						
☐ Diabetes (416855002)						
☐ Heart Disease (134439009)						
☐ High Blood Pressure (160357008)						
☐ Kidney Disease (90708001)						
☐ Arthritis (3723001)						
☐ Thyroid Disease (160302006)						
☐ Blindness (105597003)						
☐ Cataracts (160348002)						
☐ Macular Degeneration (267718000)						
☐ Glaucoma (160347007)						
☐ Retinal Detachment (42059000)						
☐ Crossed Eyes (22066006)						

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Notice of Privacy Practices

Effective September 20, 2013

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. If you have any questions please contact our office. We are required by law to: Maintain the privacy of your protected health information, give you this notice of our duties and privacy practices regarding health information about you, and follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:

Described as follows are the ways we may use and disclose health information that identifies you (Health Information, or PHI). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to us and stating that you wish to revoke permission you previously gave us.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment. However, if you pay for your services yourself (e.g. out-of-pocket and without any third party contribution or billing), we will not disclose Health Information to a health plan if you instruct us to not do so.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the care you receive is of the highest quality. Subject to the exception above if you pay for your care yourself, we also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operations.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you. We will not, however, send you communications about health-related or non health-related products or services that are subsidized by a third party without your authorization.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through an approval process. Even without approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising and Marketing. Health Information may be used for fundraising communications, but you have the right to opt-out of receiving such communications. Except for the exceptions detailed above, uses and disclosures of Health Information for marketing purposes, as well as disclosures that constitute a sale of Health Information, require your authorization if we receive any financial remuneration from a third party in exchange for making the communication, and we must advise you that we are receiving remuneration.

Other Uses. Other uses and disclosures of Health Information not contained in this Notice may be made only with your authorization.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or

problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our office.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our office.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our office.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our office. ***We are not required to agree to all such requests.*** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing, to our office. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.avalonparkeyecare.com. To obtain a paper copy of this notice please request it in writing.

Right to Electronic Records. You have the right to receive a copy of your electronic health records in electronic form.

Right to Breach Notification. You have the right to be notified if there is a Breach of privacy such that your Health Information is disclosed or used improperly or in an unsecured way.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. **You will not be penalized for filing a complaint.**