PATIENT INFORMATION **Today's Date:** ________________________

Last Name: ____ **First Name**: ______________________________________ **M** or **F**

Name Preference: ____________________________ **DOB**: _________/______/_________ **SSN**: _________ -_______ -___________

Address: ____ **City** _________________________ **ST** ____ **Zip** _____________

Phone Number: ____________________________ **Email Address:** ____

Primary Care Physician: _____________________________ _______________________ **Height**: __________ **Weight:** ___________

Reason for Today's exam ____ **Are you Pregnant? Y / N Nursing? Y / N**

Medical (check & list)	**Self**	**Medications - List Names**	**Relative - List Relationship**
Diabetes [Type 1 / Type 2]			
High Blood Pressure			
Cholesterol			
Heart Disease			
ADHD			
Alzheimer's			
Arthritis			
Asthma			
Autism / Asperger's			
Behavioral / Psychiatric			
Cancer (list type)			
Headaches / Migraines			
Herpes / Shingles			
HIV / AIDS			
Seizures			
Thyroid [Hyper / Hypo]			
Other Not Listed			
Allergies to Medications?			

Ocular (check & list)	**Self**	**Medications - List Names**	**Relative - List Relationship**
Glaucoma			
Macular Degeneration			
Dry Eye			
Eye Surgery / Lasik			
Eye Allergies			
Other Not Listed			

Do you use tobacco products? NO YES If Yes: Type: _________________ Amount ________________ For How Long ______________

Do you drink alcohol? NO YES If Yes: Type: _________________ Amount ________________ For How Long ______________

Do you use illegal drugs? NO YES If Yes: Type: _________________ Amount ________________ For How Long ______________

Do you currently wear glasses? Y / N Will you be updating your glasses today? Y / N / unsure

Do you wear contacts? Y / N - INTERESTED or UPDATING contacts today? Y / N - Are you WEARING contacts today? Y / N

*** Dilation or Optos is <u>REQUIRED</u> for a full health examination and a complete eye exam. ***

Dilation side effects include light sensitivity and blurred vision for up to 6 hours. **Please CIRCLE one and Sign on both lines below:**

I would like <u>Optos</u> ($32) / I would like to <u>dilate</u> **Signature** ____

I have read and understood the HIPAA privacy policy provided **Signature** ____

HIPPA STATEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: 1) Conduct, plan and direct my treatment and follow up among the multiple health care providers who may be involved in that treatment directly or indirectly. 2) Obtain payment from third party payers. 3) Conduct normal healthcare operations such as quality assessments and physical certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at this address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time to the extent that you have taken action relying on this consent.

Patient Name: ____

Signature: ____

Relationship to Patient: _____________________________________Date: ___________________________