

NEW PATIENT INFORMATION

Welcome to our office. Please complete this form and return it to the receptionist, who will use the information to prepare your chart. **PLEASE PRINT**

Date _____

Name _____ Birthdate _____ Age _____ Sex: M F
First Middle Last Mo. Day Yr.

Mailing Address _____ Phone (____) _____
Include apt. # or box # City State Zip

e-mail _____ Cell Phone (____) _____

Temporary Address _____ Phone (____) _____
Include apt. # or box # City State Zip

Employer _____ Work Phone (____) _____

Soc. Sec. # _____ Marital Status: Married Single Divorced Widowed

Spouse's Name _____ Employer _____ Work Phone (____) _____

Emergency Contact: Name _____ Relationship _____
Home Phone (____) _____ Work Phone (____) _____

Who recommended us? _____
Name

=====

Insurance Information

Please identify your health insurance carrier. I do not have insurance coverage.

Medicare # _____ Medicaid # _____

Medicare Supplement (if applicable) _____ Policy # _____

Blue Cross/Blue Shield # _____

Workers Compensation (job injury): Yes No If yes, to whom is bill to be sent? _____

Other Insurance _____ Policy # _____

Policy Holder's Name (if other than patient) _____

Relationship to Patient : Spouse Parent Other _____
Please Specify

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Authorization to Release

I request that payment of authorized Medicare/insurance benefits be made either to me or on my behalf to Randy Burks, M.D., F.A.C.S.; Ray Gailitis, M.D., F.A.C.S.; David Silver, O.D. or Ophthalmology Consultants for services rendered to me by the same.

I authorize any holder of medical records, or other information about me, to release to my insurance company or the Health Care Financial Administration and its agents any information needed to determine these benefits for related services.

Signature (Patient, or parent if minor) _____

Print Name _____ Date _____

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. You may request the detailed Notice from our office staff.

Date of Last Revision: 1/7/03
Effective Date: Immediately

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.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As your patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices document):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders.
- To run our Practice more efficiently and ensure all our patients receive quality care.
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

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

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these rights, please request the detailed Notice of Privacy Practices document from our office staff.

PRIVACY NOTICE CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____
Sign and print name

Relationship to Patient (if other than patient): _____

Date: / /

In front of _____
Sign and print name

Medical History Questionnaire

Patient Name: _____

Date: _____

Do you currently have, or have you ever had any of the following medical conditions? (Check any conditions that apply or circle the specific problem)

_____ High blood pressure	_____ Diabetes	_____ Irregular heart rhythm
_____ Heart murmur or valve problem	_____ Heart attack	_____ Asthma or Emphysema
_____ Hepatitis or liver Cirrhosis	_____ Kidney failure or stones	_____ Blood flow problems
_____ Stroke, seizures, headaches	_____ Bleeding disorders	_____ Cancer _____
_____ Other _____		

Are you allergic to any medications? _____ No _____ Yes (Please list)

1. _____ 2. _____ 3. _____

Have you ever had surgery? _____ No _____ Yes (include all surgeries including eye surgeries)

Eye Surgeries	Approximate Date	Other Surgeries	Approximate Date
1. _____	_____	1. _____	_____
2. _____	_____	2. _____	_____
3. _____	_____	3. _____	_____
4. _____	_____	4. _____	_____

Please list all medications that you **currently** take. Attach a separate list if necessary.

General Medications		Eye Medications (which eye and how often)
1. _____	5. _____	1. _____
2. _____	6. _____	2. _____
3. _____	7. _____	3. _____
4. _____	8. _____	4. _____
Vitamins _____		5. _____

Who is your primary medical doctor? _____ Phone: _____

Who are your medical specialists? 1. _____ Phone: _____

2. _____ Phone: _____

Please continue on the back.

Have **you** ever had or do you have any of the following eye conditions?

Cataracts Glaucoma Floaters Diabetic Retinopathy
 Lazy eye Crossed Eyes Retinal detachment Macular Degeneration
 Eye Injury Wear Contact Lenses Refractive Surgery
 Other _____

Is there a history **in your family** of:

Hypertension Diabetes Glaucoma Macular Degeneration
 Other _____

Do you smoke? No Yes _____ packs per day

Do you drink alcohol? No Yes _____ drinks per day

What is your occupation? _____

Do you currently suffer from any of the following: (**please circle any conditions that apply**)

<u>General:</u>	Fevers	Weight loss		
<u>Ear Nose Throat:</u>	Decreased hearing	Sinus problems	Teeth problems	Throat problems
<u>Heart:</u>	Irregular heart beats	Chest pain	Swollen ankles	
<u>Lungs:</u>	Shortness of breath	Wheezing	Chronic cough	
<u>Stomach and Bowel:</u>	Trouble swallowing	Nausea	Vomiting	Dark stools
<u>Urinary:</u>	Frequent urination	Pain or burning	Blood in the urine	
<u>Muscles and Joints:</u>	Arthritis	Muscle cramps	Back pain	
<u>Skin:</u>	Suspicious lesions	Rashes		
<u>Neurological:</u>	Tremors	Numbness	Frequent Headaches	
<u>Mental:</u>	Anxiety	Depression		
<u>Hormone:</u>	Thyroid problems	Menopause		
<u>Blood-Immune:</u>	Anemia	Swollen glands	Frequent illnesses	

Patient signature: _____

Medical History and Review of Systems reviewed by: _____