PATIENT INFORMATION

Patient Last Name: _____ Legal First Name: _____

Circle: Male/Female Age: _____ Date of Birth: _____/_____/_____

Race: White Black American Indian/Alaska Native Asian Native Hawaiian/Pacific Islander

Occupation:_____

Address: _____

City/Zip Code_____

Home Phone: _____ Cell Phone: _____

Email Address: _____

HIPAA PRIVACY

By signing this HIPAA privacy form, 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 this location may use and disclose necessary personal health information (i.e. name, address, exam information) to another party in order to perform its administrative duties, provide eye care services and products, process my vision benefit claims, and communicate with me regarding vision care services provided at this location. I can be assured that this location does not sell my personal health information to a third party for such party's own use.

_____ _____

Patient's/Guardian's Signature Date

HEALTH INFORMATION

Check all conditions that apply:

	Self	Family
Crossed or Lazy Eye	☐	☐
Eye Injury	☐	☐
Eye Infection	☐	☐
Cataracts	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Diabetes	☐	☐
Thyroid	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Heart Disease	☐	☐
Prostate	☐	☐
Arthritis	☐	☐
Allergies	☐	☐
Cancer	☐	☐
Migraines	☐	☐
Stroke	☐	☐
Seizures	☐	☐
Respiratory	☐	☐
Hepatitis	☐	☐
HIV/AIDS	☐	☐
Autoimmune	☐	☐

Any conditions not listed:_____

Surgeries:_____

Medications:_____

_____

_____

Drug Allergies: Y N _____

Smoking: Current Past Never

Pregnant: Y N

Signature:_____ Date:_____

Retinal Photo Consent Form

Retinal photos allow us to take a picture of the back of your eyes to document your ocular health. This provides a baseline for future exams. We strongly recommend this tool for all our patients. The doctor will discuss the results of the photos with you during the exam. The fee for this procedure is $40.00 and is not billable to insurance.

_____ Yes, I consent to retinal photos

_____ No, I do not consent to retinal photos

Signature _____ Date_____