

KRAMER FAMILY VISION PATIENT INFORMATION FORM

Name _____ Date of Birth _____
First Name MI Last Name

Address _____ SS# _____
Street City State Zip

Marital Status _____ Occupation _____ Workplace _____
Race/Ethnicity: African American Asian Caucasian Hispanic/Latino American Indian Other

Check One: HOW DO YOU PREFER WE CONTACT YOU FOR CONFIRMING APPOINTMENTS OR NOTIFYING FOR ORDERS?

- TEXT: Cell Phone _____ Carrier: AT&T Verizon Other _____
 E-MAIL: _____
 PHONE CALL/LEAVE A MESSAGE: _____ / _____ / _____

HEALTH HISTORY

Average daily computer use: _____ hours

Date of last eye exam _____ Doctor/Place _____			
Have you ever worn glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Contact Lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____			
HAVE YOU EVER BEEN TREATED OR DIAGNOSED WITH ANY OF THE FOLLOWING?			
<input type="checkbox"/> Eye Surgery	<input type="checkbox"/> Macular Degeneration		
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Eye Injury		
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Retinal Problems		
<input type="checkbox"/> Blindness	<input type="checkbox"/> Strabismus/Crossed Eye		
<input type="checkbox"/> Amblyopia/Lazy Eye			
DO YOU EXPERIENCE ANY OF THE FOLLOWING?			
<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Burning	<input type="checkbox"/> Flashes of Light	<input type="checkbox"/> Light Sensitivity
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Itching	<input type="checkbox"/> Floaters	<input type="checkbox"/> Redness
<input type="checkbox"/> Dry Eye	<input type="checkbox"/> Tearing	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Unexplained Headache
IS THERE A FAMILY HISTORY OF THE FOLLOWING? (please indicate relation next to condition: M, F, GM, GF, B, S)			
<input type="checkbox"/> Glaucoma _____	<input type="checkbox"/> Retinal Problems _____	<input type="checkbox"/> Diabetes _____	
<input type="checkbox"/> Blindness _____	<input type="checkbox"/> Macular Degeneration _____	<input type="checkbox"/> Cancer _____	
<input type="checkbox"/> "Lazy" Eye _____	<input type="checkbox"/> Cataracts before age 40 _____	<input type="checkbox"/> Heart Disease _____	
<input type="checkbox"/> Hypertension _____	<input type="checkbox"/> High Cholesterol _____	<input type="checkbox"/> Heart Disease _____	
<input type="checkbox"/> Kidney Disease _____	<input type="checkbox"/> Cataracts before age 40 _____	<input type="checkbox"/> Stroke _____	
Date of last routine health appt _____ Name of Regular Physician _____			
HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?			
<input type="checkbox"/> Currently Ill _____	<input type="checkbox"/> Hepatitis A B C	<input type="checkbox"/> Thyroid Problem: Hypo / Hyper / _____	
<input type="checkbox"/> Cardiovascular Problems	<input type="checkbox"/> Arthritis: Osteo / Rheumatoid	<input type="checkbox"/> Anemia	
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Muscle Pain or Disorders	<input type="checkbox"/> Sickle Cell Anemia	
<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Blood Clot/Bleeding	
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Skin Disorders	<input type="checkbox"/> HIV/AIDS	
<input type="checkbox"/> Pace Maker	<input type="checkbox"/> Stroke/Neurological	<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Cancer (type/when) _____	
<input type="checkbox"/> Ear/Nose/Throat Problems	<input type="checkbox"/> Depression	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Diabetes (Type 1 or 2) _____	<input type="checkbox"/> Currently Pregnant	
<input type="checkbox"/> Gastrointestinal Problems	(Date of Diagnosis) _____	How far along? _____	
DO YOU USE TOBACCO PRODUCTS? <input type="checkbox"/> Never Smoked <input type="checkbox"/> Everyday Smoker <input type="checkbox"/> Occasional Smoker <input type="checkbox"/> Former Smoker <input type="checkbox"/> Smokeless			
DO YOU USE ALCOHOL? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> 3 or less per week <input type="checkbox"/> 4 or more per week <input type="checkbox"/> Social			
DO YOU USE ANY OTHER SUBSTANCES? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any special needs? <input type="checkbox"/> Yes <input type="checkbox"/> No _____			
DO YOU USE ANY EYEDROPS? (include over the counter) _____ PREFERRED PHARMACY _____			
LIST ALL MEDICATIONS/SUPPLEMENTS & DOSING (or provide medication list to receptionist): _____			
LIST ALL ALLERGIES: (include allergies to MEDICINE or ENVIRONMENTAL SUBSTANCES): _____			
HOW DID YOU HEAR ABOUT US?			
<input type="checkbox"/> Phonebook <input type="checkbox"/> Newspaper <input type="checkbox"/> Internet <input type="checkbox"/> Friend/Family _____ <input type="checkbox"/> Other _____			
PLEASE CONTINUE ON THE BACK SIDE			

Insurance Information: All charges not covered by the insurance carrier will be the responsibility of the patient.

Vision insurance will cover routine services and glasses--benefits only covered once per year (or every 2 years).

Medical insurance MAY cover the examination if there is a medical problem with the eyes.

Vision Insurance: Company _____ Relationship to Insured _____

Policy Holder's Name _____ Policy Holder's Date of Birth _____

Policy Holder's Social Security # _____ (This is only necessary if you do not have a vision card)

Medical Insurance:

Primary Insurance Company _____ Relationship to Insured _____

Policy Holder's Name _____ Policy Holder's Date of Birth _____

Secondary Insurance Company _____ Relationship to Insured _____

Policy Holder's Name _____ Policy Holder's Date of Birth _____

I attest that the information included on this form is correct to the best of my knowledge

I understand the HIPAA Privacy Policy as stated below and I understand that a copy of the full privacy practices of Kramer Family Vision may be furnished upon request.

Patient Signature: _____ **Date:** _____

Summary of HIPAA NOTICE OF PRIVACY PRACTICES

WE MAY USE YOUR INFORMATION FOR TREATMENT PURPOSES BY:

- Setting up an appointment or confirmation of an appointment already made (including reminder postcards and messages left on an answering machine).
- Testing or examining your eyes; Prescribing glasses, contact lenses, or eye medications (and faxing them to be filled) ; showing you vision therapy or low vision aids .
- Referring you to another doctor or clinic for eye care, surgery, low vision aids, or vision therapy services or getting copies of your health information from another professional.

WE MAY USE YOUR INFORMATION FOR PAYMENT PURPOSES BY:

- Asking about health and vision care plans or other sources of payment.
- Preparing and sending bills or claims.
- Collecting unpaid amounts (ourselves or through a collection agency or attorney).

WE MAY USE YOUR INFORMATION TO MAINTAIN THE HEALTH CARE OPERATIONS OF OUR OFFICE BY:

- Financial or billing audits, Internal quality assurance, Personnel decisions, Participation in managed care plans, Defense of legal matters, Business planning, or Outside storage of records

*We routinely use your health information inside our office for these purposes without any special permission.

*If we need to disclose your health information outside our office for these reasons, we will ask you for special written permission.

USES/DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION:

We are obligated to release your information in the following circumstances:

- When mandated by state or federal law that certain health information be reported.
- Disclosures to governmental authorities regarding victims of suspected abuse, neglect, or domestic violence.
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies.
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime.
- Unless you object, we will also share relevant information about your eye care with your family or friends who are helping you with your eye care.