Medical History Questionnaire

Name: _____ Today's Date ____/____/____

Address: _____ Phone: _____

_____ Work Phone: _____

Guardian (If Applicable): _____ Birth Date: ____/____/____

Social Security #: ____/____/____ How many years since your last *eye* exam? _____

Name of Medical Doctor: _____ How many years since your last *medical* exam? _____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❒ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Occupation: _____

Do you drive? ❒ no ❒ yes If yes, do you have visual difficulty when driving? ❒ no ❒ yes If yes, please describe:

_____

Do you use tobacco products? ❒ no ❒ yes If yes, type / amount / how long: _____

Do you drink alcohol? ❒ no ❒ yes If yes, If yes, type / amount / how long: _____

Do you use illegal drugs? ❒ no ❒ yes If yes, type / amount / how long: _____

Have you ever been exposed to or infected with: ❒ Gonorrhea ❒ Hepatitis ❒ HIV ❒ Syphilis

Have you ever had a blood transfusion? ❒ no ❒ yes _____

Medical History

Do you have any allergies to medications? ❒ no ❒ yes If yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

Are you pregnant and/or nursing? ❒ no ❒ yes

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Do you wear glasses? ❒ no ❒ yes If yes, how old are your present pair? _____

Do you wear contact lenses? ❒ no ❒ yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: ❒ Rigid ❒ Soft ❒ Extended Wear ❒ Other Are they comfortable? ❒ no ❒ yes

Sports & Safety Eyewear: Many eyeglass and contact lens wearers have hobbies and job needs that require a special pair of glasses. We encourage all of our patients to wear Sports/Safety eyewear during these activities. The eyewear you receive to wear on a daily basis are dress eyewear only — they do not meet the Safety Eyewear Standards.

Have you or any of your blood relatives (living or deceased) had any of the following?									
Disease	**Yes**	**No**	**Self**	**Relationship**	**Disease**	**Yes**	**No**	**Self**	**Relationship**
Diabetes					Glaucoma				
High blood pressure					Cataracts				
Heart disease					Blindness				
Thyroid disease					Macular Degeneration				
Stroke					Crossed Eyes				
Cancer					Lazy Eye				
Cholesterol					Drooping Eye Lid				
Arthritis					Eye Injury or Infections				
Lupus					Other Eye Disease				

PATIENT NAME: _____ **EMAIL:** _____

RESPONSIBLE PARTY

Name of person responsible for this account _____

Relationship to patient _____ Phone (_____) _____
(If different from above.)

Address _____ City _____ ST _____ Zip _____

Occupation _____

Name of Employer / School _____ Work Phone (_____) _____

Do you prefer to receive reminder calls at: __ Home __ Work __ Cell __ Email __ No Preference

May we leave a message on your answering machine? __ Yes __ No

Patient Marital Status: __ Married __ Widowed __ Single __ Minor

__ Separated __ Divorced __ Partnered for _____ years

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ (_____) _____

INSURANCE INFORMATION

Primary Insurance _____

Secondary Insurance _____

If insurance is in name other than patient, please provide primary insured's:

Name: _____ SSN: ___-___-_____ DOB: ___/___/_____

Address _____ City _____ ST _____ Zip _____

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with: _____
Name of Insurance Company

and assign directly to Dr. Wanda Batson, and/or Dr. Cynthia L. Peeterse all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor(s) may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

_____ _____
Signature of patient, guardian or personal representative Date

REVIEW OF SYSTEMS

Patient Name: _____

Please check if you have/had problems related to the areas indicated within the past 6 months.

1. HEART ☐ YES ☐ NO
If yes, describe _____

_____

High Blood Pressure? ☐ YES ☐ NO

3. ENDOCRINE ☐ YES ☐ NO
If yes, describe _____

_____

Diabetes? ☐ YES ☐ NO

4. GASTROINTESTINAL ☐ YES ☐ NO
If yes, describe _____

_____

5. GENITOURINARY ☐ YES ☐ NO
If yes, describe _____

_____

6. EARS, NOSE & THROAT, HEAD
☐ YES ☐ NO
If yes, describe _____

_____

7. BLOOD/LYMPH NODES ☐ YES ☐ NO
If yes, describe _____

_____

8. SKIN ☐ YES ☐ NO
If yes, describe _____

_____

9. MUSCLE/SKELETAL ☐ YES ☐ NO
If yes, describe _____

_____

10. NERVOUS SYSTEM ☐ YES ☐ NO
If yes, describe _____

_____

11. PSYCHIATRIC ☐ YES ☐ NO
If yes, describe _____

_____

12. LUNGS/RESPIRATORY ☐ YES ☐ NO
If yes, describe _____

_____

13. EYE COLOR _____

For Staff use only: Date Reviewed _____ by _____

Shalimar EYE CARE

1201-B Eglin Parkway, Shalimar, FL 32579
Office: 850.613.6588 Fax: 850.613.6574

NO SHOW & LATE ARRIVAL POLICY

Effective November 1, 2013 we will implement a new **no show** and **late arrival policy.**

We understand that circumstances arise and you may not be able to keep a scheduled appointment. If you need to cancel or reschedule an appointment, we kindly ask for 24 hours notice. Should an emergency or situation arise where that is not possible, we will work with you the best our schedule allows. If you are running more than 15 minutes late and our schedule is full, we will attempt to work you in as time allows, so as not to cause further delay to other patients' scheduled appointments. This may not always be an option if it is late in the day or the schedule is completely booked for the remainder of that day. You may be rescheduled for another day.

Three no show appointments without a timely call to cancel will result in you being changed to a walk-in only patient Walk-ins will be seen as space becomes available. It is our hope that this is a step we will never have to take. We appreciate all of our patients and believe this will help us better serve everyone.

Thank you,

Shalimar Eye Care Staff

_____
Patient Signature

_____
Date

Patient Portal

In order to better serve our patients, we are now offering access to a secure patient portal from which you will have access to your records, prescriptions, and other information online. Please provide an email address to begin this process. **We will use this email address for the patient portal, appointment reminders, office closure notices, and notifications of office events such as our annual Trunk Show.** Your email will remain securely within our office records for the above purposes and will not be given to third parties. If you provide your email address, you will receive access to the portal via an email. If you do not provide an email address, a username and password will be generated and available to you within the next two business days. Once you have logged in to the portal, please send us a message from within the portal letting us know you were able to view your record. By logging in and sending us a message, you help us to meet current government guidelines.

_____ _____

Signature of Patient Date

_____

Patient Email Address

* Secure messaging portal utilizes HIPAA-approved data encryption and SSL support which ensures security and is password protected.

Notice of Privacy Practices

Form 7.20

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (ie.) name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule
Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication - This means you have the right to ask us to contact you about medical matters using an alternative method (ie., telephone), and to a destination (ie., cell phone number, alternative address, etc.) designated by you. You must in inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment. payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request. You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Pro[illegible] Health Information
Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints
You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

Shalimar Eye Care • 1201-B Eglin Parkway, Shalimar, FL 32579
We will not retaliate against you for filing a complaint.

If you would like to authorize us to disclose your protected health information to a family member or caregiver, please list below.

X _____ Effective Date _____
Signature of patient/legal guardian (Authorization valid for 1 year from date of signature)

_____ Relationship _____
Name of authorized Family Member/Caregiver

Contact info _____

_____ Relationship _____
Name of authorized Family Member/Caregiver

Contact info _____