Name:______________________________ Today's Date:________

Main Reason for Eye Exam:______________________________

Review of Systems: Present History of Symptoms

Do you currently have any problems in the following areas:

CONSTITUTIONAL

fever	Yes No	weight loss/gain	Yes No
allergies	Yes No	sinus congestion	Yes No
runny nose	Yes No	post-nasal drip	Yes No

NEUROLOGICAL

headaches	Yes No	migraines	Yes No
seizures	Yes No	parkinson's	Yes No
alzheimer's	Yes No		

PSYCHIATRIC

depression	Yes No	ADHD/ADD	Yes No
anxiety	Yes No	bi polar	Yes No

VASCULAR/CARDIOVASCULAR

heart pain	Yes No	high blood pressure	Yes No
vascular disease	Yes No	cholesterol	Yes No

RESPIRATORY

asthma	Yes No	chronic bronchitis	Yes No
emphysema	Yes No		

GASTROINTESTINAL

acid reflux	Yes No	intestinal problems	Yes No
liver/spleen problems	Yes No		

GENITOURINARY

genital/kidney/bladder	Yes No	pregnant/nursing	Yes No

BONES/JOINT/MUSCLES

rheumatoid arthritis	Yes No	muscle/joint pain	Yes No

INTEGUMENTARY(SKIN)

rosacea	Yes No	metal allergies	Yes No

ENDOCRINE

thyroid/other glands	Yes No	diabetes/gestational	Yes No

LYMPHATIC/HEMATOLOGIC

anemia	Yes No	bleeding problems	Yes No

EYES

loss of vision	Yes No	blurred vision	Yes No
distorted vision/halos	Yes No	loss of side vision	Yes No
double vision	Yes No	dryness	Yes No
mucous discharge	Yes No	redness	Yes No
sandy/gritty feeling	Yes No	itching	Yes No
burning	Yes No	foreign body	Yes No
watering	Yes No	glare/light sensitivity	Yes No
pain or soreness	Yes No	infection of eye or lid	Yes No
styes/chalazion	Yes No	flashes/floaters	Yes No

EYE HISTORY

eye injuries Yes No
eye surgery Yes No
eye disease Yes No

FAMILY HISTORY:
please note any family history for the following conditions:

DISEASE/CONDITION		RELATIONSHIP TO YOU
blindness	Yes No	parents-sibling-grandparent-relative
cataract	Yes No	parents-sibling-grandparent-relative
eye turn	Yes No	parents-sibling-grandparent-relative
glaucoma	Yes No	parents-sibling-grandparent-relative
macular degeneration	Yes No	parents-sibling-grandparent-relative
retinal detachment	Yes No	parents-sibling-grandparent-relative
arthritis	Yes No	parents-sibling-grandparent-relative
cancer	Yes No	parents-sibling-grandparent-relative
diabetes	Yes No	parents-sibling-grandparent-relative
heart disease	Yes No	parents-sibling-grandparent-relative
high blood pressure	Yes No	parents-sibling-grandparent-relative
kidney disease	Yes No	parents-sibling-grandparent-relative
lupus	Yes No	parents-sibling-grandparent-relative
thyroid disease	Yes No	parents-sibling-grandparent-relative

list **(ALL MEDICATION)**you are taking: Yes No:______________________________

____

Are you allergic to any medications,etc? Yes No: if yes explain:__________________
Do you use tobacco products? Yes No: if yes type/amount/how long:_______________
How many alcoholic beverages do you drink pre week?__________________________
Do you wear glasses? Yes No: if yes how old is your present pair of glasses?
____
Are you interested in contact lenses? Yes No
Are you using a computer for more than 2hrs at a time during the day or night? Yes No
Are you participating in sports,hobbies or work that you need eye protection? Yes No
Do you have any difficulty driving at night? Yes No
Would you prefer the thinnest and lightest lenses available? Yes No
Would you like to receive appointment reminders via email? Yes No: if yes provided email address:____

Patients Name:______________________________**DOB:**______________

Address:____________________________**City:**____________**Zip:**______

WK#______________**Home#**______________**Cell#**_________________

Email:___________________________**SS#:**________________________

School(only if patient is a student)**:**________________________**Grade:**_______

Employer:_____________________________**Occupation:**______________

INSURED INFORMATION:

Insured's Name:______________________________**DOB:**_____________

SS#:________________**Employer:**_______________________________

Address(if different from patient)**:**_____________________________________

Cell#:________________**WK#:**_________________**Home#:**_____________

In Office Use Only

Frame benefit:______________________________**Overage Due:** **Yes** **No**

Lens benefit:_______________________________**Overage Due:** **Yes** **No**

Total allowance:_____________________________**Overage Due:** **Yes** **No**

Hammond Vision Center

Notice of Privacy Practices

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relations to your past, present, or future physical or mental health or condition and related health care services.

By law, we must abide by the terms of this Notice of Privacy Practices. We reserve the right to change this notice at any time in compliance with and as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have as well as to information that we maybe generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office and have copies in our office.

Uses and Disclosures of Protected Health Information

Treatments: we use information for treatment purposes, when, for example we set up and appointment for you, when our technician or doctor tests your eyes, when the doctor prescribes glasses or contact lenses, and when we show you low vision aids. We may disclose your health information outside of our office for treatment purposes if, for example, we refer you to another doctor or clinic for eye care or low vision aids or services, if we send a prescription for glasses or contact to another to be filled, when we provide a prescription for medication to a pharmacist, or when we phone to let you know that your glasses or contact lenses are ready to be picked up. Sometimes we may ask for copies of your health information from another professional that you may have seen before us.

Payment: We use your protected health information to obtain payment for your health care services. For example, our staff asks you about health or vision care plans that you may belong to, or about other sources of payment for our services, when we prepare bills to send to you or your health or vision care plan, when we process payment by credit card, and when we try to collect unpaid amounts due. We may disclose your health information outside of our office for payment purposes when, for example, bills or claims for payment are mailed, faxed, or sent by computer to you or your health or vision plan, or when we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due. Our staff also discloses your protected health information to third party payers/insurance companies to obtain information regarding eligibility or converge for insurance benefits.

Your Rights to Privacy of Health Information

You have the right to inspect and copy your protected health information. You have the right to ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions you want. You have the right to ask us to amend your protected health information if you think that is incorrect or incomplete. In certain cases, we may deny our request for an amendment.

Patient Acknowledgment

Patient Name: ____________________

Date of Birth: ____________________

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practice's legal duties with respect to my protected health information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that is maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: ____________________

Date: ____________________

Relationship to Patient ____________________

Hammond Vision Center

Financial Agreement and Release of Medical Information

Insurance Benefits:

_____ I authorize South Texas Eye Clinic to furnish information concerning my visit to my insurance carrier and assign to the provider all insurance payments for medical/ vision services rendered on my behalf.

_____ I understand that verification of insurance eligibility and benefits is not a guarantee of payment, and that payment of insurance benefits is determined only when the claim is processed by the insurance carrier. I agree to assume financial responsibility for all co-payments, coinsurance, deductibles, denied, or non-covered services.

Financial Responsibility:

_____ I understand all accounts are the full responsibility of the patients and/or the patient's responsible party/guarantor. In cases of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection to this account or future outstanding accounts.

______________________	________________
Patients' Signature	Date
______________________	________________
Parent/Guardian	Date