

Patient History & Update

Name (First) _____ (Last) _____ Sex _____ Date _____
 Address _____
 City _____ State _____ Zip _____ Email _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Marital Status _____ Occupation _____ DOB ____/____/____
 Patient Social Security # _____ Employer _____

Insurance Information

(Complete this section only if you have coverage for today's visit)

Who is responsible for this account? _____ Relationship _____
 Insured's Name _____ DOB ____/____/____ SS# _____
 Insured's Employer _____
 Employer Address _____
 Insurance Company _____
 Individual ID# _____ Group # _____

Assignment & Release: I, the undersigned, certify that I or my dependents have insurance coverage with _____ and assign directly to **Peachtree Corners Eye Clinic** all 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 the insurance company for any reason. I hereby authorize the Doctor to release any information necessary to secure the payment of benefits for services rendered. In addition, I also authorize the use of my signature on all insurance claims.

Signature of responsible party _____ Date ____/____/____

Eye and Health History

Reason for today's visit _____
 How did you hear about our practice? _____
 Date of last eye exam? ____/____/____ Doctors _____
 Do you wear contacts? Y ___ N ___ How many hours of the day? _____ Do CL's get dry? _____
 Do you wear glasses? Y ___ N ___ ,year made ____ Do you wish to discuss all vision correction options? Y ___ N ___

****List severity of following symptoms using this scale: 0 = Never; 1 = Occasionally, 2 = more than 4 times a year 3 = Frequently and increasing 4 = All the time and severe**

Bloodshot eyes _____ Burning eyes _____ Discharge from eyes _____ Dry eyes _____ Itching eyes _____
 Light Sensitivity _____ Twitching eyelid _____ Floaters or spots _____ Eye strain _____ Eye pain _____
 Cloudy vision _____ Double vision _____ Poor color vision _____ Cross eye _____ Flashes _____
 Headaches _____ Blurred vision (Far) _____ Blurred vision (Near) _____ Poor night vision _____
 Physicians Name _____ Address _____

Do you have sleep apnea / snore? _____ Are you taking any medications? Y ___ N ___

List: _____

Are you allergic to any medications? _____

General Family Health History

	<u>Yourself</u>	<u>Family</u>		<u>Yourself</u>	<u>Family</u>
AIDS/HIV	Y N	Y N	Hepatitis	Y N	Y N
Arthritis	Y N	Y N	High Blood Pressure	Y N	Y N
Cancer	Y N	Y N	Kidney Disease	Y N	Y N
Cataracts	Y N	Y N	Breathing problems	Y N	Y N
Blindness	Y N	Y N	Thyroid Condition	Y N	Y N
Diabetes	Y N	Y N	Glaucoma	Y N	Y N
Heart Condition	Y N	Y N	Tuberculosis	Y N	Y N

List any other conditions, surgeries, and treatments: _____

Are you pregnant? Y ___ N ___ Use Tobacco? Y ___ N ___ Drink alcohol? Y ___ N ___

Reviewed by: Dr. _____

We provide our patients the option to participate in our online patient communication system. Some of the features include the ability to:

***Have direct communication with Doctor and Staff *Request appointments online *Confirm appointments via email *Submit patient Satisfaction Reviews *Receive Text appointment reminders *Monthly Newsletters**

Choose one or both options ___ Text Messages (appointment confirmations ONLY)

___ Email Communication

PEACHTREE CORNERS EYE CLINIC
Richard Shuster, OD
Notice of Privacy Practices

- This notice describes how your health information may be used and disclosed. Please review it carefully.
- At Peachtree Corners Eye Clinic, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the phone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- You may request in writing that we not use or disclose your health information as described above.
- As we will need to contact you from time to time, we will use whatever address, telephone numbers or email address we have on file.
- You have the right to transfer copies of your health information to another practice.
- You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request or sign a records release form in regards to the information you are requesting.
- If we change the details of this notice, we will notify you of the changes in writing.
- You may file a complaint with the Department of Health & Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, D.C. 20201.
- However, before filing a complaint, or for information or assistance regarding your health information privacy, please contact our Privacy Officer, Tonia Palmer, at 770-441-1211.
- This notice goes into effect as of April 1, 2003.

Acknowledgement

I have read a copy of the Peachtree Corners Eye Clinic Notice of Privacy Practices.

Signed: _____ Print Name: _____ Date: ____/____/____

If signing as a parent or guardian, please note the name of the patient: _____