New View
OPTOMETRY

Patient Information

Last Name: _____ **First**_____ **M.I.**____ **Today's Date:** _____

Nickname:_____ **(Gender: M F)** **Occupation:**_____

Address: _____ **Home Phone:**_____

City: _____ **State:** _____ **Zip:** _____ __ **Cell Phone:**_____

Date of Birth: ____/____/____ **SSN**_____-_____-_____ **Work Phone:** _____

Parent/Guardian (if applicable)_____ **E-Mail:**_____

Primary Care physician: _____ **Last Eye Exam:** _____

Pharmacy name and phone number: _____

Referred by (Doctor or personal):_____

How did you hear about us (Facebook, Instagram, google, newspaper, website, drive-by):

HIPAA Notice and Acknowledgement

I acknowledge that I have been provided the HIPAA Notice of Privacy Practices ___Yes ____No

Chief Complaint: What is your primary reason for this visit? _____

_____

Are you experiencing any of the following ocular or visual symptoms? (Check all that apply)

Blurred Vision	____	Light Sensitivity	____	Reduced Night Vision	____
Burning Eyes	____	Itchy, Watery Eyes	____	Reduced Side Vision	____
Excessive Tearing	____	Dry, Gritty Feeling	____	Halos around Lights	____
Noticeable Redness	____	Pain or Discomfort	____	Flashes or Flickers	____
Double Vision	____	New Floaters/Spots	____	Loss of Vision	____

Have you ever been diagnosed with, or treated for, any of the following ocular conditions?

Retinal Detachment	____	Ocular Infections	____	Lazy or Turned Eye	____
Cataracts	____	Glaucoma	____	Styes, Inflamed Lids	____
Macular Degen.	____	Disease of Retina	____		

Do you now wear glasses? _____ If so, how old are they? _____

How is your vision with them? _____ Are they comfortable? _____

What type? ____ Readers ____Distance ____ Bifocal ____ Trifocal ____Progressive

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Do you use a computer?_____ How many hours per day? _____
Any previous surgeries or injuries to your eyes?_____ If so, please describe_____
_____
Using any ocular medicines? _____ Please list if known: _____
What hobbies, activities, and/or sports do you enjoy? _____

Would you be willing to provide feedback to us on your experience today via a text message or e-mail survey? ____Yes ____No

Medical History:
Do you have any allergies to medicines?_____ If so, please list: _____
Are you taking any Rx or OTC medicines?_____ If so, please list: _____
_____
Any previous injuries, surgeries, or hospitalizations? _____
_____
Are you pregnant or nursing? _____ If pregnant, list due date:_____

Have you been diagnosed with or treated for any of the following problems? (Check all that apply)

Cardiovascular
- Heart Problems ____
- High Blood Pressures ____

Constitutional
- Fever ____
- Weight Gain ____
- Weight Loss ____
- Dizziness/Fainting ____

Endocrine ***(Check one)***
- Diabetes: ____
  ___ ***Type 1*** ___ ***Type 2***
- Thyroid Disorder: ____
  ___ ***Hypo*** ___***Hyper***
- Elevated Cholesterol ____

Gastrointestinal
- Gastrointestinal Disorder ____
- Hepatitis ____
- Gallbladder ____
- Ulcers ____

Genitourinary
- Bladder Infection ____
- Kidney Stones ____

Cranial/Facial
- Chronic Cough ____
- Dry Mouth ____
- Sinus Infection ____
- Ear Infection ____
- Hearing Loss ____

Hematologic/Lymphatic
- Anemia ____
- Clotting/Bleeding Disorders ____

Immunologic
- HIV/AIDS ____
- Syphilis ____
- Lupus ____
- Mononucleosis ____
- Shingles ____

Musculoskeletal
- Arthritis ____
- Joint Pain ____
- Muscle Pain ____

Neurological
- Headaches ____
- Migraines ____
- Seizures ____
- Bell's Palsy ____
- CP/MS/MD/MG ____

Psychiatric
- Depression ____
- ADD/ADHD ____
- Alzheimer/Dementia ____

Respiratory
- Asthma ____
- Chronic Bronchitis ____
- Emphysema, COPD ____
- Tuberculosis ____

Allergy:
Food: If so, please list: _____
Seasonal: If so, Please list: _____

Social History:
Do you drive? ____yes ____No If yes, are you having any visual difficulties? _____
Do you use tobacco products? ____Yes ____No If so, how often? _____
Do you use alcohol? ____Yes ____No If so, how often? _____
Do you have a history of drug or alcohol abuse? ____Yes ____No If yes, how long? _____
Have you ever been exposed to HIV or other sexually transmitted diseases? ____Yes ____No

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Family Medical History:

In your immediate family, is there any history of the following conditions?

Blindness: Injury___ Disease____		Relationship: _____
Turned or Lazy Eyes	____	Relationship: _____
Cataracts	____	Relationship: _____
Glaucoma	____	Relationship: _____
Macular Degeneration	____	Relationship: _____
Retinal Detach/Disease	____	Relationship: _____
Arthritis	____	Relationship: _____
Cancer	____	Relationship: _____
Heart Disease	____	Relationship: _____
High Blood Pressure	____	Relationship: _____
Kidney Disease	____	Relationship: _____
Lupus	____	Relationship: _____
Diabetes: ***(Check one)***		
___ ***Type 1*** ___ ***Type 2***	____	Relationship: _____
Thyroid Disease: ***(Check one)***		
___ ***Hypo*** ___***Hyper***	____	Relationship: _____

ATTENTION CONTACT LENS PATIENTS:

A contact lens fitting is a professional service separate from the routine vision exam. The fitting includes the trial lenses and any follow-up appointments to provide you with a contact lens prescription. By signing below, you acknowledge that you can use your insurance benefits to cover the contact lens fitting, **OR** you will pay for the contact lens fitting at the time of service.

Signature (patient/ responsible party)_____ Date_____

Do you currently wear contact lenses?_____ What type/brand?_____ Hours per day?_____

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Patient Insurance Information

Vision Plan or Medical Insurance being billed today:

Primary's Name: _____ Primary's DOB: _____/_____/_____
Name of Plan or Insurance: _____ Primary's Employer: _____
Member ID or SSN Number: _____ Group Number: _____

Medical Consent to Treatment

The doctor at New View Optometry is licensed to provide both routine vision exams and medical eye exams. If you are here today for a routine vision exam and your complaint or initial assessment indicates that there is a significant medical condition that requires treatment, you will be either provided with appropriate treatment today; referred to the appropriate specialist for treatment; or rescheduled for a medical examination. New View Optometry is not a contracted provider for medical visits so the charges for your visit will be payable at the time of service. The doctor will discuss any such condition with you prior to initiating medical treatment, and it is your responsibility to consent to treatment or request referral to the appropriate specialist.

Acknowledgements and Signature

I acknowledge that the health and insurance information I have provided above is true and correct to the best of my ability. I authorize payment of any vision or medical benefits I may be eligible for directly to New View Optometry. **I agree that if my employer, insurance carrier, or plan sponsor denies payment to all or any part of my claim, I will be financially responsible for all outstanding charges.** I acknowledge that authorization obtained at the time of service does not guarantee payment, and any services not covered by insurance will be billed to me. In the event it becomes necessary to place any unpaid balances I am responsible for in collection, I agree to pay any collection fees, reasonable attorney fees, filing fees, and other costs the court determines are proper. I have read the conditions of service, and as the Patient or the Patient's Authorized Representative I hereby accept these terms.

Signature of Patient or Responsible Party _____ **Date:** _____

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Internal Eye Examination Options

An annual internal health evaluation is considered a necessary part of every comprehensive eye examination. Previously the internal exam was performed using dilating eye drops. At New View Optometry, our doctors have invested in state-of-the art technology as an alternative to the dilating drops.

At New View Optometry we value your time, comfort and budget so we have provided you with 3 options to choose from for your internal exam. Please initial from the following

____ 1) **Dilation** $0
Cost is included in price of comprehensive exam
Drops may cause temporary discomfort (stinging, burning, redness)
Drops cause light sensitivity and blurry vision up close for about 5 hours
Appointment time will be approximately 30-45 minutes longer

____ 2) **Retinal photo** $25
This is the most popular choice of patients
Shorter total appointment time
Able to go back to work or school after (no blurry vision)
Captures permanent image for annual comparison

____ 3) **Wellness package** $40
Indicated for patients 50 and above
Indicated for patients with diabetes
Family history of glaucoma or macular degeneration
Includes retinal photo and OCT imaging (similar to an ultrasound)

Patient name (please print): _____

Signature: _____ Date: _____

HIPAA POLICY
NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information.
The right to amend your protected health information.
The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the polices and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact the following for more information:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775