



Confidential Patient Intake Form

Mr. Mrs. Miss Ms. Dr. SS# Today's date Last Name First MI Gender DOB Address Home Ph Cell Ph City State Zip E-mail Occupation Employer Date of last eye exam Were you dilated? Yes / No Referred by Emergency contact name(s) Phone number(s)

Personal Eye Information

Reason(s) for visit Eye Exam First time contact lens fitting Update for current contact lenses Refit contact lenses Medical problem Do you have any of the following? (circle all that apply or check here if none apply) Blurred vision Glaucoma Cataracts Dry eyes Macular degeneration Retinal detachment Flashes / Floaters Do you have any other eye conditions or problems? Yes / No Describe Have you had any eye injuries or surgeries? Yes / No Describe Do you wear glasses? Yes / No Contact Lenses? Yes / No What type? Additional information

General Medical Information

What is your general health? Date of last physical exam Date of last tetanus shot Name of family doctor Phone # Pregnant? Yes / No / N/A

Do you have problems with any of these systems? (Please circle yes or no)

Cardiovascular (Heart) Yes / No Urinary / Genital Yes / No Endocrine (glands) Yes / No High Blood Pressure Yes / No Muscles / Bones Yes / No Blood / Lymph Yes / No Ears / Nose / Throat Yes / No Integumentary (Skin) Yes / No Allergic / Immunologic Yes / No Respiratory (Lungs) Yes / No Nervous System Yes / No Headaches Yes / No Gastrointestinal Yes / No Psychiatric Yes / No Eyes Yes / No

Please explain Diabetes Yes / No Type Date of diagnosis Last blood sugar count Last A1C Allergies to medication? Yes / No Which? Reactions? Other health problems Currents medication(s) (check if none) Have you had any surgeries? Yes / No Which? When? Additional information

Family History

High blood pressure Yes / No Relation Macular degeneration Yes / No Relation Diabetes Yes / No Relation Retinal detachment Yes / No Relation Glaucoma Yes / No Relation Cataracts Yes / No Relation

## Dilation Information

It is our goal to provide a complete and thorough comprehensive eye examination. To effectively accomplish our goal, we feel it is important to dilate the pupils of your eyes. This will require placing drops in your eye.

As with many medications, there are some side effects of the drops used to dilate the pupil. These include sensitivity to light and blurred reading vision. In most cases, the distance vision will not be affected. The side effects usually last several hours but can, in some instances, last up to 24 hours.

While we believe that dilation is an important part of the eye examination process, we understand that you may wish to defer or decline this procedure. **Please indicate your preference below.**

I wish to be dilated today.

I do not wish to be dilated and agree to hold *Trinity Family Eyecare, P.A* harmless as a result of my actions.

## HIPPA Compliance Acknowledgement of Receipt:

I acknowledged that I received a copy of *Trinity Family Eyecare, P.A* notice of privacy practices.

**Patient or Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_\_\_

### If you are using insurance, please complete the following section:

Name of insurance \_\_\_\_\_

Primary insured's name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Primary's DOB \_\_\_/\_\_\_/\_\_\_\_\_

**(Please note that verification of Insurance does not guarantee payment from the insurance company)**

### Lifetime Patient Signature (Your signature below is required to bill your insurance company)

I request that payment of authorized Medicare, Medicaid, or other insurance benefits either to me or

On my behalf be made to *Trinity Family Eyecare, P.A.* for any services furnished to me by the doctor.

I authorize any holder of medical information about me to release to my insurance company or *Centers*

*For Medicare and Medicaid Services* and its agent any information needed to determine these benefits or

the benefits payable for related services. I also understand that if my insurance company does not provide

payment to *Trinity Family Eyecare, P.A* I will be held responsible for said service(s) and or product(s).

**Patient or Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_\_\_



## Hippa Privacy Statement

***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. This Notice Goes Into Effect as of April 14, 2003.***

At Trinity Family Eyecare, P.A., 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. The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lens, or eye medications and faxing them to be filled; referring you to another doctor or clinic for eye care; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans, defense of legal matters; and business planning.

We routinely use your health information inside our office for these purposes without any special permission. For example, one of our staff will enter your information into our computer. We may also use your information to contact you. For example, we may send annual eye exam recall cards and birthday cards to you. We also will call to remind you about scheduled appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. You have the right to request, in writing that we do not send you any office mailings. You also have the right to ask that we confirm your appointments at whatever telephone number you prefer.

In the case of 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. If this practice is sold, your information will become the property of the new owner.

Except as described on the previous page, this practice will not use or disclose your health information without your prior written request. You may request in writing that we not use or disclose your health information as previously described. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the described normal uses. You have the right to transfer copies of your health information to another practice or to have your prescriptions sent to another facility. A written request from you must be made, either in person, by fax or by mail before our office will release your health information or prescriptions.

You have the right to see and receive a copy of your health information, with a few exceptions. We will need a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies. You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. 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 and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Office Manager at (813)406-4993.