Patient Information:

Vision Coverage:_____

Medical Coverage:_____

Patient's First Name:_____

Patient's Last Name:_____

Patient's Address:_____

Apt #:_____

City:_____

State:_____ Zip Code:_____

Patient's Email:_____

Home Telephone:_____

Cell Phone:_____

Insured's Employer:_____

Insured ID:_____

Group ID:_____

Patient's Date of Birth:_____

If Patient is NOT the Primary Member:

Members Name:_____

Members Address:

_____

_____

_____

Member's Phone #:_____

Relationship to Patient:_____

Members Date of Birth:_____

Male or Female:_____

Pharmacist Info:

Pharmacy Name:_____

Pharmacy Address:

_____

_____

_____

Pharmacy Phone #:_____

Check One:

Gender: □ M / □ F

Marital Status: □ Single / □ Married / □ Separated / □ Divorced / □ Widowed

Employment Status: □ Active / □ Retired / □ Unemployed / □ Student

Name: _____ Date: _____

Social History

Do you drive? ☐ No ☐ Yes
Do you use tobacco products? ☐ No ☐ Yes: How many packs/day? _____ Years smoking? _____
Do you use illegal drugs? ☐ No ☐ Yes: How frequently? _____

Ocular History

Last eye exam: _____ ago
Do you or have you worn glasses? ☐ No ☐ Yes, how old is your most recent pair; _____
Do you or have you worn contact lenses? ☐ No ☐ Yes, which brand and prescription are you currently wearing:
_____
_____

Do you have an eye disease/ocular condition? ☐ No ☐ Yes, Explain: _____
Have you had an eye infection, eye injury or eye surgery? ☐ No ☐ Yes, Explain: _____
_____

Have you worn an eye patch or had vision therapy? ☐ No ☐ Yes, Explain: _____
_____

Medical History

Medical Doctor: _____
Last medical physical exam with primary care doctor: _____ ago
Do you have any allergies to medications or other substances?
☐ No ☐ Yes, Explain: _____
_____

Are you taking any medications? (Including birth control, aspirin, OTC meds, home remedies)
☐ No ☐ Yes, Explain: _____
_____

Have you had any major injuries or hospitalizations? ☐ No ☐ Yes, Explain: _____
_____

Women: are you pregnant or breastfeeding? ☐ No ☐ Yes

Family History

(Note any family history, including parents, grandparents, siblings and/or children; living or deceased)

Glaucoma ☐ No ☐ Yes, who: _____
Blindness ☐ No ☐ Yes, who: _____
Retinal Disease/Detachment ☐ No ☐ Yes, who: _____
Heart Disease ☐ No ☐ Yes, who: _____
Thyroid Disease ☐ No ☐ Yes, who: _____
Cancer ☐ No ☐ Yes, who: _____
Macular Degeneration ☐ No ☐ Yes, who: _____
Crossed eyes ☐ No ☐ Yes, who: _____
Cataracts ☐ No ☐ Yes, who: _____
Diabetes ☐ No ☐ Yes, who: _____
Arthritis ☐ No ☐ Yes, who: _____
High Blood Pressure ☐ No ☐ Yes, who: _____

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

Constitutional

Fever, Weigh Loss/Gain	☐ No	☐ Yes	☐ ?
Integumentary (Skin)	☐ No	☐ Yes	☐ ?
Neurological	☐ No	☐ Yes	☐ ?
Headaches	☐ No	☐ Yes	☐ ?
Migraines	☐ No	☐ Yes	☐ ?
Seizures	☐ No	☐ Yes	☐ ?

Eyes

Loss of Vision	☐ No	☐ Yes	☐ ?
Blurred Vision	☐ No	☐ Yes	☐ ?
Distorted Vision/Halos	☐ No	☐ Yes	☐ ?
Loss of Side Vision	☐ No	☐ Yes	☐ ?
Double Vision	☐ No	☐ Yes	☐ ?
Dryness	☐ No	☐ Yes	☐ ?
Mucous Discharge	☐ No	☐ Yes	☐ ?
Redness	☐ No	☐ Yes	☐ ?
Sandy or Gritty Feeling	☐ No	☐ Yes	☐ ?
Itching	☐ No	☐ Yes	☐ ?
Burning	☐ No	☐ Yes	☐ ?
Foreign Body Sensation	☐ No	☐ Yes	☐ ?
Excess Tearing/Watering	☐ No	☐ Yes	☐ ?
Glare/Light Sensitivity	☐ No	☐ Yes	☐ ?
Eye Pain or Soreness	☐ No	☐ Yes	☐ ?
Chronic Infection or Eye or Lid	☐ No	☐ Yes	☐ ?
Sties or Chalazion	☐ No	☐ Yes	☐ ?
Flashes/Floaters in Vision	☐ No	☐ Yes	☐ ?
Tired Eyes	☐ No	☐ Yes	☐ ?

Endocrine

Diabetes	☐ No	☐ Yes	☐ ?
Thyroid/Other Glands	☐ No	☐ Yes	☐ ?

Vascular/Cardiovascular

High Blood Pressure	☐ No	☐ Yes	☐ ?
High Cholesterol	☐ No	☐ Yes	☐ ?
Chest Pain	☐ No	☐ Yes	☐ ?
Vascular Disease	☐ No	☐ Yes	☐ ?

Patient Name_____ M F Date_____

Chief Complaint | Eye(s) | First Noticed

Contact Lens Wearer Complaints

- ☐ Change in vision R L Both _____
- ☐ Fluctuating Vision R L Both _____
- ☐ Reduced Wearing time R L Both _____
- ☐ Discomfort / Intolerance R L Both _____
- ☐ Red Eyes R L Both _____
- ☐ Light Sensitivity R L Both _____

General Complaints

- ☐ Change in Vision R L Both _____
- ☐ Fluctuating Vision R L Both _____
- ☐ Red Eyes (watery / itchy / mucous) R L Both _____
- ☐ Light Sensitivity R L Both _____
- ☐ Swollen Lids upper / lower / both R L Both _____
- ☐ Floaters R L Both _____
- ☐ Flashes of light R L Both _____
- ☐ Pain in / around eye(s) R L Both _____
- ☐ Double Vision R L Both _____
- ☐ Eye(s) are Dry R L Both _____
- ☐ Foreign Body Sensation R L Both _____
- ☐ Headaches
  Frontal / Partial / Temporal / Occipital
  Morning / Afternoon / Evening / Constant _____

Additional:

_____

_____

Medical History & ROS from __/__/__ reviewed: ☐ no changes _____
(Dr. Initials)

Doctor Signature: _____

Patient Authorization Form

Calendar Year 20____

Vision People of Bellmore

- I hereby assign, transfer and set over to the above named physician group and facility sufficient monies and or benefits to which I may be entitled from government agencies, insurance carries and/or others who are financially liable for the cost of care and treatment rendered to the patient.

- I authorize the above named physician group and facility to release any and all records, medical history, services rendered, or treatment given to the patient for purposes of review, investigation or evaluation of any claim submitted to my insurer(s).

- I authorize the transferring of any and all necessary personal medical or demographic information required by the pharmacy in order to fill or refill medication prescriptions. I understand that this information may be transferred electronically, verbally or in writing.

_____ _____

Date Signature of Patient/Guarantor

_____

Printed Name of Signee

Patient Name: _____

PRIVACY NOTICE

VISION PEOPLE OF BELLMORE
2766 SUNRISE HWY
BELLMORE, NY 11710

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS TO THIS INFORMATION.
PLEASE REVIEW CAREFULLY

Effective April 14, 2003
The privacy of your medical information is important to us. You may be aware that the U.S. government regulators established privacy rule ("HIPPA") governing protected health information. This notice tells you about how it may be used, and about certain rights that you have.

Your rights: Although the records containing your medical information are the physical property of Vision People of Bellmore, the information belongs to you. By law, you have the right to:

Inspect and obtain a copy of your medical information. Generally, we will respond to your request within 30 days but, under certain circumstances, we may deny your request.

Request a restriction on certain uses and disclosures of your medical information; however, we are not required to agree to a requested restriction.

Request an amendment of your medical information, if you believe it is inaccurate; however, we may deny your request for the amendment if we believe your medical insurance is accurate.

Request an accounting of certain disclosures we have made, if any, of your medical information.

Revoke any authorization you have provided to use or disclose your medical information except to the extent that action has already been taken in reliance on such authorization.

Our Duties: We are required by law to:
Maintain the privacy of your medical information.
Provide you with a copy of our Notice of Privacy Practices.

How We May Use and Disclose Your Medical Information
The following are the examples of the types od uses and disclosures of your medical information that are permitted:

Treatment: We may use and disclose your medical information to provide, coordinate or manage your health care and any related services. For example, we may disclose your medical information to doctors or technicians that care for you, even if the doctors or technicians are not affiliated with **VISION PEOPLE OF BELLMORE.**

Payment: Your medical information may be disclosed, as needed, to obtain payment from your insurance company or other person/party responsible for payment for services we provide to you. For example, we may disclose your medical information to your health plan to determine your eligibility or coverage for insurance benefits.

Health Care operations: We may use or disclose your medical information for our internal operations, which include activities necessary to operate the **VISION PEOPLE OF BELLMORE** sites or programs from which you receive services. For example, we may use your medical information for quality improvement services to evaluate the care or other services provider to you. We may also use your medical information to evaluate the skills and qualifications of our health care providers, or to resolve grievances within our organization.

Appointment Reminders and Treatment Alternatives: We may use and disclose your medical information to provide a reminder to you about an appointment you have with us for treatment or medical care. We may also use or disclose your medical information to tell you about or recommend possible treatment options or alternatives, or inform you or other health related benefits and services, that may be of interest to you.

I have received a paper copy of this notice

Signature _____ Print Name _____

Date _____