RONALD N. CAUCHARD O.D.

Name_____ Date_____

Address, City, State, & Zip_____

Social Security #_____ DOB_____

Home #_____ Cell #_____

Emergency Contact Name & Number_____

Email Address_____

Primary Ins._____ Secondary Ins._____

REVIEW OF HEALTHSYSTEMS (ROS)

***EYES**: Have you had or do you have any of the following:*

Macular degeneration: ☐Yes ☐No **Glaucoma:** ☐Yes ☐No **Dry Eyes:** ☐Yes ☐No

Other eye problems: _____

DISCUSSION OF GENERAL HEALTH SYSTEMS (please check box that applies)

***SKIN:** ☐No problem ☐Eczema ☐Cancer ☐Rash ☐Psoriasis ☐Dry

***GASTROINTESTINAL:** ☐No problem ☐Ulcer ☐Colitis ☐Heartburn

***EARS/NOSE/THROAT:** ☐No problem ☐Sinusitis ☐Colds ☐Upper Respiratory Infections

***ENDOCRINE:** ☐No problem ☐Hormonal Dysfunction ☐Thyroid ☐Diabetes

***CARDIOVASCULAR:** ☐No problem ☐High Blood Pressure ☐Heart disease ☐Stroke
☐Chest pain ☐Vascular ☐Disease Irregular ☐Heart beat ☐TIA

***RESPIRATORY:** ☐No problem ☐Asthma ☐Emphysema ☐Coughing ☐Bronchitis ☐COPD

***ALLERGIC IMMUNE:** ☐No problem ☐Allergies ☐Lupus ☐Arthritis ☐HIV ☐Drug Allergy

***BLOOD/LYMPH:** ☐No problem ☐Anemia ☐Leukemia

***NEUROLOGICAL:** ☐No problem ☐Epilepsy ☐Headaches ☐Numbness

***CONSTITUTIONAL:** ☐No problem ☐Fever ☐Weight loss ☐Fatigue ☐Trauma ☐Developmental

***PSYCHIATRIC:** ☐No problem ☐Depression ☐Bipolar ☐ADD

***GENITOURINARY:** ☐No problem ☐STD ☐Blood in Urine ☐Bladder infection

***MUSCULAR:** ☐No problem ☐Osteoarthritis ☐Muscle Aches ☐Joint pain ☐Muscular dystrophy

PAST, FAMILY AND SOCIAL HISTORY (PFSH+)

***+PATIENT PAST HISTORY:** Have you had any eye injuries, infections or surgery?*_____

_____

_____

HISTORY: Do you smoke? ☐Yes ☐No Do you use drugs? ☐Yes ☐No

Do you consume alcoholic beverages? ☐Yes ☐No

+Please list any medications, including over the counter medications:_____

_____

***+FAMILY HISTORY:** Any family members with the following conditions:*

☐HBP ☐Diabetes ☐Cataracts ☐Glaucoma ☐Retinal Problems ☐Macular Degeneration

Patient Signature_____ Date_____ DR_____ROS PFSH

Referred by_____

Date Reviewed_____ No Change/Change_____

Date Reviewed_____ No Change/Change_____

Date Reviewed_____ No Change/Change_____

ROS PP-1 EXT 2-9 COMP 10-14 PFSH 1 2 3

PATIENT CONSENT FORM

The Department of Health and Human Services has established a Privacy Rule to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent and disclosures of health information including treatment, payment, and health operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take responsible precautions to protect your privacy. When it is appropriate and necessary we provide the minimum amount of information to only those we feel are in need of your health care information that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationship with you, such as laboratories that only interact with physicians and not patients, and may have to disclose personal health information for the purpose of treatment, payment, and health operations. These entities are most often not required to obtain patient consent.

You may refuse to the right to consent to the use or disclosure of your personal health information but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent at any future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken or a previously signed consent.

If you have any objections to this form please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ **Signature:** _____

Date: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our valued patients,

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the Privacy Rule. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of the PHA in accordance with the government rules, laws, and regulations. We want to insure that our practice never contributes to the growing problem of improper disclosure of the PHI. AS part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of the PHI.

Thank you for being one of our highly valued patients.