Medical Group, Inc.

NEW PATIENT INFORMATION SHEET

PLEASE PRINT

Patient's Name ______________________ **Birth Date** __________ **Age** _____

☐Married ☐Single ☐Widowed ☐Divorced ☐Separated ☐Male ☐Female

Address ______________________ **City** ______________

State __________ **Zip Code** __________ **Tel.** ( ) ______________

Social Security # _______-_______-_______ **Driver's License #** ______________

Alternate Phone Number and/or Cell # ( ) ______________________

Employed By ______________________ Phone ______________

Business Address ______________________ Occupation ______________

Responsible Party (If Minor) ______________________ Phone ______________

Employed By ______________________ Phone ______________

Business Address ______________________ Occupation ______________

Social Security # ______-_____-______ DOB __________ Driver's License # ______________

Emergency Contact: ______________________

Patient Referred By ______________________

Do you have Medical or Vision Insurance? ☐No ☐Yes: ☐Medical ☐Vision __________

Member's Name (If other than Patient): ______________________

Member's Social Security # _______-_______-_______ **DOB:** __________

Name of Insurance(s)______________________

Was your condition caused by work or accident? ☐Yes ☐No

I request that payment for authorized medical benefits be made on my behalf to any doctor of North Valley Eye Medical Group, Inc. for services rendered by that physician or supplier.
I authorize the release of any medical information necessary to process these claims to the insurance carrier(s) listed above or its agents.

______________ ______________________________

Date **Patient's or Responsible Party Signature**

PAYMENTS ON ACCOUNTS: The office bill is due and payable at the time it is presented. An agreement covering payment of the bill may be made with the Office Manager. I understand that I am directly and fully responsible to North Valley Eye Medical Group, Inc. for all medical bills rendered. In the event that a service is not covered by my insurance and/or only partially covered by my insurance, I realize that I am financially responsible for the balance due. In the event that litigation is necessary to collect fees for services rendered, I am responsible for payment of all attorney, court costs, and any other costs incurred to collect payment due.

______________ ______________________________

Date **Patient's or Responsible Party Signature**

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 for uses and disclosures of health information about the patient to carry out treatment, payment, or health care 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 reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care 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 relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse 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 in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this 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 may 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 use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

MEDICAL HISTORY QUESTIONNAIRE

Name ____ Date ______________

Date of **birth** ______________ Date of **last eye exam** ______________

List any **medications** you currently take (prescription and over-the-counter):

____

____

Do you have **allergies** to any medications? ☐ YES ☐ NO
If YES, list the medications:

____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

____

____

List any **surgeries** you have had (cataract, tonsillectomy, appendectomy):

____

____

____

Do you *currently* have any problems in the following areas? If "YES", please provide information.

	YES	NO	Explanation of Problem
EYES (Glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL/CONSTITUTIONAL			
Fever			
Weight loss			
Other			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			

CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)			

FAMILY HISTORY

M=mother F=father S=sibling GP=grandparent

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation: ______________________

Education (high school, vocational school, college degree): ______________________

Marital Status (married, divorced, single, widowed): ______________________

Living Arrangements: ______________________

Do you drive? ☐ YES ☐ NO

Do you have visual difficulty when driving? ☐ YES ☐ NO

Do you have problems with night vision? ☐ YES ☐ NO

Have you ever tried to wear contact lenses? ☐ YES ☐ NO

Do you currently wear contact lenses? ☐ YES ☐ NO

If YES, how long have you worn contact lenses? ______________________

Do you currently wear glasses? ☐ YES ☐ NO

If YES, how long have you had the current prescription? ______________________

Do you drink alcohol? ☐ YES ☐ NO If YES: occasional 1 per day 2-3 /day 4+ /day

Do you smoke? ☐ YES ☐ NO If YES: occasional ½ pack/day 1 pack/day 1+ pack

Have you ever had a blood transfusion? ☐ YES ☐ NO

History reviewed. ☐ No Changes. ☐ Additions as noted above.

Physician's Signature: Date: