Patient History Questionnaire

Patient Name: _____ Birth Date: _____

Address: _____ SSN: _____

_____ Home Phone: _____

Email: _____ Cell Phone: _____ ☐Text Ok?

Occupation: _____ **Preferred Contact Method**:☐Call☐Text☐Email

Race: ☐African-American ☐Asian ☐Caucasian ☐Hispanic ☐Native Indian ☐Native Hawaiian/Pacific Islander

Primary Care Physician: _____ Date Last Seen: _____ Driver's License: _____

Medical Insurance: _____☐ HMO☐ PPO Vision Insurance:☐ None☐ MES☐ VSP☐ Other _____

Subscriber: _____ Subscriber Employer: _____ Relationship to insured:_____

Ocular History:

	Y	N	
Do you wear glasses?	☐	☐	If yes, how old are they? _____ Date of Last Exam: _____
Do you wear contacts?	☐	☐	If yes, what type?☐ Soft ☐Hard/RGP Brand: _____
Ocular Drops	☐	☐	Any allergic reactions to eye drops? ☐Yes☐No
Eye surgeries	☐	☐	If yes, list all surgeries: _____
Eye Injuries	☐	☐	If yes, describe injury: _____
Eye infections	☐	☐	If yes, what kind of infection? _____

Disease/Condition	**Yourself** Y	N	**Family Member** Y	N	**Relationship** (All blood related family members. Maternal/Paternal Parent, Grandparent, Sibling, etc.)
Cataracts	☐	☐	☐	☐	_____
Blindness	☐	☐	☐	☐	_____
Glaucoma	☐	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	☐	_____
Retinal Detachment	☐	☐	☐	☐	_____

Family History	**Family Member** Y	N	**Relationship** (All blood related family members. Maternal/Paternal Parent, Grandparent, Sibling, etc.)
Diabetes	☐	☐	_____
Cancer	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Lupus/Arthritis	☐	☐	_____

Medical History:

Please list any medications you are currently taking, including contraceptives, vitamins and over-the-counter medications (If you have a list, we are happy to photocopy for you instead): _____

Are you allergic to any medications? ☐No ☐Yes If yes, please list: _____

List all major surgeries or hospitalizations you have had: _____

_____

Review of Systems: Please indicate below if you have or ever had problems with the following conditions:

Allergic/Immunologic
□ None
□ Seasonal/Environmental Allergies
□ Lupus
□ Rheumatoid Arthritis
□ Auto-immune _____

Cardiovascular
□ None
□ Arteriosclerosis
□ High Blood Pressure
□ High Cholesterol

Constitutional
□ None
□ Sleep Apnea
□ Weight Loss
□ Weight Gain
□ Fever
□ Fatigue

Gastrointestinal
□ None
□ IBS
□ Acid Reflux/Ulcer
□ Other _____

Hematologic/Lymphatic
□ None
□ Anemia or Bleeding Disorder
□ Leukemia
□ Breast Cancer

Ears, Nose & Throat
□ None
□ Sinus Congestion
□ Dry Throat, Mouth

Endocrine
□ None
□ Diabetes Type 1 or 2 (circle one)
□ Thyroid Dysfunction

Neurological
□ None
□ Migraines
□ Dizziness/Vertigo
□ Seizures
□ Stroke

Muscle/Skeletal
□ None
□ Arthritis
□ Fibromyalgia
□ Muscle Pain
□ Joint Pain

Respiratory
□ None
□ Asthma
□ Bronchitis
□ Emphysema
□ Chronic Cough
□ Other _____

Skin/Integumentary
□ None
□ Cancer
□ Eczema
□ Rosacea
□ Other _____

Psychiatric
□ None
□ Anxiety
□ Depression
□ Memory Loss
□ Other _____

Genitourinary
□ None
□ Kidney Disease
□ Ovarian/Uterine Cancer
□ Prostate Cancer
□ Sexually Transmitted Disease (STD)

I acknowledge that this form is current:

_____ _____
Patient/Guardian Signature Date

Social History

Tobacco Use: (Circle One)
Current Smoker| Former Smoker| None

Non-Prescription Drugs: ☐ Yes ☐ No

Alcohol Consumption: (Circle One)
Social| 1-2 Daily| Above Avg| None

Weight: _____ lbs

Height: _____ in

Acknowledgement of Receipt of Notice of Privacy Practices

My signature below verifies that I have read 17th Street Optometry, APC's Notice of Privacy Practice.

_____ _____ _____
PRINT NAME PATIENT/GUARDIAN SIGNATURE DATE

Insurance Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I request that payment of these benefits be made either to me or on my behalf to 17th Street Optometry, APC for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated on Item 9 of CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to my insurer or agency shown, and authorizes my doctor to act as my agent, as above.

_____ _____
LIFETIME PATIENT SIGNATURE DATE

RE: Release form

Dear Dr. _____:

I authorize you to release my records or a copy of my records to the following office as soon as possible:

Cynthia Broady, O.D.
Alexander Elson, O.D.
17300 E. 17th St. Suite M
Tustin, CA 92780
Phone: (714) 838-9664
Fax: (714) 838-6774

Thank you for your cooperation.

_____
Patient's signature

(Please print)

Patient's name_____
Address _____
_____
Telephone _____

NOTICE OF PRIVACY PRACTICES AS OF April 1ST, 2019

17th Street Optometry, APC
17300 E. 17th St. Suite M * Tustin, CA 92780
714-838-9664
714-838-6774 * Staff@17thStreetOptometry.com * Office contact: Ninoua Kando

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESSTO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record. You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting us at (310)-568-0193. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to 1) Share information with your family, close friends, or others involved in your care 2) Share information in a disaster relief situation 3) Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission: 1) Marketing purposes 2) Sale of your information 3) Fundraising - We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways. 1) Treat you. We can use your health information and share it with other professionals who are treating you. 2) Run our organization. We can use and share your health information to run our practice, improve your care, and contact you when necessary. 3) Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**
Help with public health and safety issues. We can share health information about you for certain situations such as 1) Preventing disease 2) Helping with product recalls 3) Reporting adverse reactions to medications 4) Reporting suspected abuse, neglect, or domestic violence 5) Preventing or reducing a serious threat to anyone's health or safety
Do research. We can use or share your information for health research.
Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests. We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law **enforcement, and other government requests.** We can use or share health information about you: 1) For workers' compensation claims 2) For law enforcement purposes or with a law enforcement official 3) With health oversight agencies for activities authorized by law 4) For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

1) We are required by law to maintain the privacy and security of your protected health information. 2) We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 3) We must follow the duties and privacy practices described in this notice and give you a copy of it. 4) We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. 5) For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html. 6) Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

APPOINTMENT REMINDERS

We may call, text, or write to remind you of scheduled appointments, or to make a routine appointment. We may also call, text, or write to notify you of other treatments or services available at our office that might help you.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new one in our office and have copies available in our office.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax, or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.