WELCOME TO OUR OFFICE

Mr. Mrs. Ms. Miss Dr. Fr. ___ Single _____ Married _____Other _____ Date _____

Last_____First_____Mi_____

Address_____ Apt _____

City_____Zip_____ Drivers License#_____

Home Phone_____ Work _____ Cell _____

Email (HIPPA complaint / not shared) _____

Date of Birth _____/_____/_____ Age _____ Social Security _____

Occupation _____Race_____Ethnicity_____

Date of last Eye Exam (estimate) _____Your Primary Doctor _____

Reason for Today's Appointment – (Please Mark the box that applies to you)

	Yes	No		Yes	No		Yes	No
Blurred Distance Vision			Itch burn or Tear			Dry Eyes		
Blurred Near Vision			Double Vision			Broken Glasses		
General Blurred Vision			Amblyopia (lazy eye)			Flashes of Light		
Want Contact Lenses			Cataract evaluation			LASIK		
Want new glasses			Diabetic Eye exam			Other		

If you marked other, please indicate your reason _____

Health History – (Do you have problems with any of these systems?)

	Yes	No		Yes	No		Yes	No
Good General Health			Stomach			Migraines		
Ear/Nose/Throat			Urinary			Mental		
Cardiovascular			Bone/ Arthritis			Pregnant		
Hypertension			Infective Disease			Diabetic		
Cholesterol			Skin			Thyroid		
Respiratory			Neurological			Allergic conditions		
Do you smoke			Drink alcohol			Drug use		

Ocular and Family History --- (Please MARK the box that applies to you and/or your family)

	Yes	No	Family		Yes	No	Family		Yes	No	Family
Glaucoma				Retinal disease				Dry Eye			
Cataracts				Other Disease				Eye Injury			
Cataract Surgery			-----	Blindness				Eye Surgery			
Macular Degeneration				Strabismus							
LASIK			-----	Amblyopia							

Please list current Medications

Name of Medication	For What Condition?	Name of Medication	For What Condition?
1.		5	
2.		6.	
3.		7.	
4			

Are you allergic to any medications YES ____NO_____ if YES, please list the medications

1	2	3
4	5	6

How Did you Hear about our office? (Please mark the box that applies)

Doctor/ Insurance Referral		**Our Website**		**Internet Search**	
Friend/Family		**Insurance website**		**Other**	

If other, Please indicate: _____

How may we contact you?

Email		**Text**		**Cell Phone**	
Letter Mail		**Insurance website**		**Other**	

If other, Please indicate: _____

GREAT EYE HEALTH MEANS PREVENTATIVE TESTING

Eye care is a preventative specialty which requires annual testing to establish excellent eye health. **This is because many diseases do not display their symptoms until permanent damage has occurred. This can include blurred vision up to total vision loss.** Therefore the doctor highly recommends specialty tests to ensure the best for your eyes. **Please read through the tests and initial. Staff will review procedures with you and answer any questions you might have.**

Digital Imaging and Retinal Mapping (Co-pays apply)

A Digital Image of your eye allows the doctor to have a better view of your retina (A collection of nerves, located in the back of the eye, that allow you to see). This test helps the doctor improve the accuracy of their treatment, as well as catch any early signs of diseases. **Without the Digital Image, It is possible to miss important health conditions. Co-pay of $15.**

Retinal Mapping allows us to see the layers of the retina in 3D. This test is incredibly important for catching early retinal detachments, macular degeneration, effects of medication, and changes due to age. **Without the retinal mapping, it's possible to miss important health conditions. Co-pay of $19.**

Please Initial _____

Dilation of the Eye (No charge)

DILATING DROPS are used to open your pupils and allow the Doctor to have a complete view of your eye. Without dilation, it's possible to miss important eye health conditions. Such conditions include ripping, tearing, stretching, and/or holes in the retina. This test is Included in your comprehensive exam at no charge.

EFFECTS OF DILATION: it is important to note, that dilation causes blurry vision for 2 – 4 hours. Shields will be provided to you, as you will be sensitive to bright lights. Do not operate machinery if you have difficultly with; walking, balance, or blurred vision. If vision has become too blurred, we recommend to wait out the effects or to coordinate other driving arrangements. Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. IF YOU HAVE PAIN IN YOUR EYES A FEW HOURS AFTER DILATION, SEEK CARE AT THE UCI ER. **Please report to the Doctor, if you have been dilated before and had adverse side effects.**

Please Initial _____

NOTICE OF PRIVACY PRACTICE (HIPPA PROTECTION)

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 IS EFFECTIVE 12/12/02 UNTIL FURTHER NOTICE. **Right to Notice** As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPAA). Dr. Chiana's Eyecare Center can use your protected health information for treatment, payment and health care operations. a) Treatment - We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. b) Payment - We may use and disclose your health information to obtain payment for services we provide you. c) Health care operations - We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. **Your Authorization** Most uses and disclosures that do not fall under treatment, payment, health care operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time. **Emergency Situations** In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare. **Marketing** We will not use your health information for marketing communications without your written authorization. **Required by Law** We may also use or disclose your health information when we are required to do so by law. **Abuse or Neglect** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety. **National Security** We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances. **Appointment Reminders** We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter. **Your Rights as a Patient** You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or health care operations. -You have the right to receive confidential communications regarding your protected health information. -You have the right to inspect and copy your protected health information. -You have the right to amend your protected health information. -You have the right to receive an account of disclosures of your protected health information. -You have the right to a paper copy of this notice of privacy practices. **Legal Requirements** Dr. Chiana's Eyecare Center is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted or are available within our office. **Complaints** If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint. **Contact Information** For further information about Dr. Steven J Chiana's Eyecare Center's privacy policies, please contact Dr. Steven J. Chiana Eyecare Center 1839 w Orangethorpe ave, Fullerton Ca 92833 (714) 879-2020 Dr. Steven Chiana or supervisior I understand that the above refers to my rights under the Health Insurance Portability and Accessibility Act (HIPAA). I may ask for a copy of this.

Patient Signature _____

ADDITIONAL FEES AND INSURANCE POLICES

*** We make no guarantees with YOUR insurance in coverage or payment. Any fee quotes are ESTIMATES only based on insurance provided information . There maybe a balance due after billing your visit due to insurance errors or denials.**
***You authorize our office to bill your vision plan or your medical plan for a routine Eye Exam or Medical care related to your eyes. Any shortfall in payment is your Responsibility and you agree to pay us promptly when notified**

Please sign _____

PLEASE PROVIDE THE STAFF WITH YOUR MEDICAL INSURANCE CARD AND VISION INSURANCE INFO