We Thank You For Choosing Our Office To Care For You

Please Print

Miss Mrs. Mr. Dr. (Please Circle)

Minor Married Single Separated Widowed (Please Circle)

Patient's Name: ______________________________Nick Name: _____________ Birthdate: _____________

Address: ____________________________ City: _____________________ ST: _____ ZIP: __________

Home Phone #: _________________ Cell Phone #________________Business Phone # __________________

Primary Language:_________________ **Hispanic/Latino Non Hispanic/Latino** (Please Circle One)

Race: Asian African American White Other (Please Circle One)

Email: _________________________________

Employer: _______________________________ Occupation: _____________________________________

Student: (Y) ______ (N) ______ Grade: _________ School: ____________________________________

Family Physician / Pediatrician Name & Phone:____

How or by whom were you referred to our Office: ____

Responsible Party

Guarantor / Name of Person responsible for this account: ____

Relationship of Guarantor to Patient: Self Parent Other (Please Circle)

Address (if different from Patient): ____

Name of Employer: _______________________________ Business phone #: _________________________

Insurance Information

Does Medicare cover you? (Y) (N) Is it your Primary or Secondary Insurance? (Please Circle)

Do you have Vision Insurance Coverage? (Y) (N) (Please circle) Name of Insurance: __________________

Name of Policy holder_________________________ Relationship to Patient___________________________

Member ID # of Policy holder___________________ Date of Birth of policyholder:______________________

Do you have Medical Insurance Coverage? (Y) (N) (Please circle) Name of Insurance: _________________

Name of Policy holder_________________________ Relationship to Patient___________________________

Member ID# of Policy Holder___________________ Date of Birth of policyholder:______________________

Authorization:

I certify that I have read and understand the information on the front and back of this questionnaire and have answered the questions accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand and agree to be financially responsible for payment of all services rendered on my behalf or my dependents.

X____

Signature of Patient (Or parent if minor) (Date)

PLEASE COMPLETE INFORMATION ON BACK

HEALTH HISTORY QUESTIONNAIRE

1. Please describe any problem or concern you have with your eyes.
____
____
____

2. Date of last exam ______________________________

3. Do you wear …?
□ Glasses For Distance □ Glasses For reading
□ Contact Lenses? □ Soft □RGP/Hard □Scleral

4. Date present glasses made__________________

5. Please list:
Computer Use ____________________Hours each day

6. How far do you sit from your computer? ______feet

7. Hobbies______________________________________
____
Outdoor activities________________________________
____

8. Are you interested in finding out more about LASIK?
□Yes □No □Maybe

9. Are you planning on getting new glasses today?
□Yes □No □Maybe

10. Are you planning on getting new contact lenses today?
□Yes □ No □Maybe

17. Please indicate if you or any blood relative has had any of the following:

You:	**Who in the family?**	**Condition:**
□	□____________________	High Cholesterol
□	□____________________	Diabetes
□	□____________________	Hypertension
□	□____________________	Hypothyroid
□	□____________________	Cataracts
□	□____________________	Rheum. Arthritis
□	□____________________	Glaucoma
□	□____________________	Macula Degen
□	□____________________	Keratoconus

11. Please check any of the problems you have with your eyes:

□ Poor night vision	□ Red or bloodshot
□ Double vision	□ Itching or burning
□ Halos around lights	□ Gritty sensation
□ See flashes of light	□ Discharge
□ Spots before your eyes	□ Pain in eyes
□ Headaches	□ Sensitivity to light
□ Color blindness	

□ Other please describe: ______________________
____
____

12. List any surgeries you've had, include any eye injuries and surgeries:
____
____

13.List all medications and supplements you are taking:
____
____
____
____
____
____

14. List all medications you are allergic to.
____
____

15. Do you smoke? □YES □ NO

16. Are you pregnant? □YES □ NO

□ Other, please specify:________________________
____
____
____
____

Aloma Eye Associates/Dr. Amy Ward

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.
At Aloma Eye Associates, we are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.
The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.
We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.
We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.
We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
In an emergency, we may disclose your health information to a family member or another person responsible for your care.
We will need to release some or all of your health information, when required by law.
If this practice is sold, your information will become the property of the new owner.
Except as described above, this practice will not use or disclose your health information without your prior written authorization.
You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.
You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.
You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.
You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.
You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
You have the right to receive a report of who we disclose your information to.
If our privacy and security measures or systems are breached in any way, we will notify you.
You have the right to receive a copy of this notice.
If we change any of the details of this notice, we will notify you of the changes in writing.
You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint.
Please contact our Privacy Officer, Cindy Kible, at (407) 671-3100 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

Acknowledgment

I have received a copy of the Aloma Eye Associates Notice of Privacy Practices Date _____________

Signed _________________________________ Print Name _________________________________

If signing as a parent or guardian, please note the name of the patient _________________________