WELCOME to GRAYS HARBOR VISION CLINIC

Dr. Scott Berken & Dr. Craig Mehlhoff

Please provide the following information and answer all questions that apply to you.

Last Name_____ First Name_____ MI___ Preferred Name_____
Address_____ City_____ State_____ Zip_____
Home Phone (___) ___-_____ Work (___) ___-_____ Cell (___) ___- _____
Email _____ Date of Birth __/__/____ Social Security # ___-__-____
Age ___ Male ☐ Female ☐ ☐
Check if you do not want to receive ***TEXT*** appointment reminders ☐

If Patient is Child: Parent or Guardian Name (for billing) _____
Parent or Guardian's Address (if different from above)_____ City_____ State____ Zip____

Vision Insurance (Primary carrier)_____ (Secondary carrier)_____
Medical Insurance (Primary carrier) _____ (Supplement) _____

YOUR PRIMARY CARE DOCTOR (especially for Diabetic Patient reports)_____
YOUR PREVIOUS EYE DOCTOR_____ ***last seen Date (approx.)***_____

Please circle or list any EYE CONDITIONS of which you have been diagnosed or treated?
Cataracts, Glaucoma , Macular Degeneration, Diabetic eye disease, Retinal Detachment, Infections, Trauma, Dry eye, Amblyopia
*Other*_____

Check if YES:
Do you Wear glasses? ☐ If yes: Reading only ☐ Distance only ☐ Both near and far ☐
Do you wear soft contacts ? ☐ **Brand if known?** _____
Do you wear gas permeable (Hard/RGP) contacts? ☐
Are you interested in trying Contacts? ☐
Are you interested in LASIK vision correction?☐ **Have you had Lasik/ PRK?** ☐ Date (approx.)_____
Have you had cataract surgery? ☐ Date (approx.)_____

If you are a new patient, how did you find us? Referred by Doctor ? *(name)*_____
Friend ? *(name)*_____ Phonebook ? ☐ Online or our Website?☐ Newspaper or Ad ? ☐ Other?_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES

I acknowledge that I received a copy of Notice of Privacy Practices for this office.
And I authorize the release of any medical or other information necessary to process insurance claims.
I also request payment of government benefits either to myself or to the party that accepts payment. I authorize payment of medical benefits to the physician or supplier for services requested.

NOTE: Most insurance companies pay only a portion of your total charges, **we do not guarantee the accuracy of benefit information provided to us by your insurance company. Please understand that the financial responsibility for your account is yours, and not your insurance company's.** If you have questions regarding your benefits and coverage, please contact your insurance company.

*Signed*_____
*Date*_____

If you are ***new*** to our office, or need to ***update Basic Health or Medications***, please fill out next page (over) ⇩

HEALTH CONDITIONS AND MEDICATIONS (*Required by Federal Regulations*)

Review of Systems: ***Please circle or list any conditions that apply to you***

1. *Constitution* Developmental Disabilities / Cancer / Fatigue Syndrome / Other
2. *Ear Nose &Throat* Hearing loss / Sinus problems / Dry mouth / Laryngitis / Sore Throat / Other
3. *Neurologic* Multiple Sclerosis / Epilepsy / Cerebral Palsy / Tumor / Stroke-CVA / Migraines / Other
4. *Psychiatric* Depression / Attention Deficit / Anxiety disorder / Bipolar disorder / PTSD / Other
5. *Cardiovascular* **Hypertension** (HighBP) / Stroke/ Heart Disease / Vascular Disease/ Congestive Heart Failure / Other
6. *Respiratory* Cigarette smoker /Asthma / Bronchitis / Emphysema / COPD / Sleep Apnea / Lung Cancer / Other
7. *GI tract* Crohn's / Colitis / Ulcer / Acid Reflux / GERT / Celiac Disease / Other
8. *Genital-Urinary* Kidney Disease/ Prostate disease or Cancer / BPH / STD / Herpes/ Chlamydia / Pregnant / Nursing
9. *Muscular/ Skeletal* Arthritis / Osteoarthritis / Fibromyalgia / Muscular Dystrophy / Osteoporosis / Gout / Other
10. *Dermatologic* Eczema / Rosacea / Psoriasis / Herpes Simplex (cold sore) / Herpes Zoster (shingles) / Other
11. *Endocrinology* **Diabetes I / Diabetes II** / Thyroid Dysfunction / Hormonal dysfunction / Other
12. *Hematological / Lymph* Anemia / Large Volume Blood Loss / Ulcer / **High Cholesterol** / HIV/ Hep C / Other
13. *Allergies / Immunologic* Rheumatoid Arthritis / Lupus / Sjogrens/ Other

Drug Allergies: _____

Environmental Allergies: Hay fever / dust / mold / animal fur / latex / Bee stings / Other_____

Food Allergies Dairy / Nuts / Shellfish / Gluten / Other_____

Other Diagnosed Conditions (not listed above) _____

Please list Prescription Medications you take: ***(or provide a list upon check-in)***

_____

_____

_____

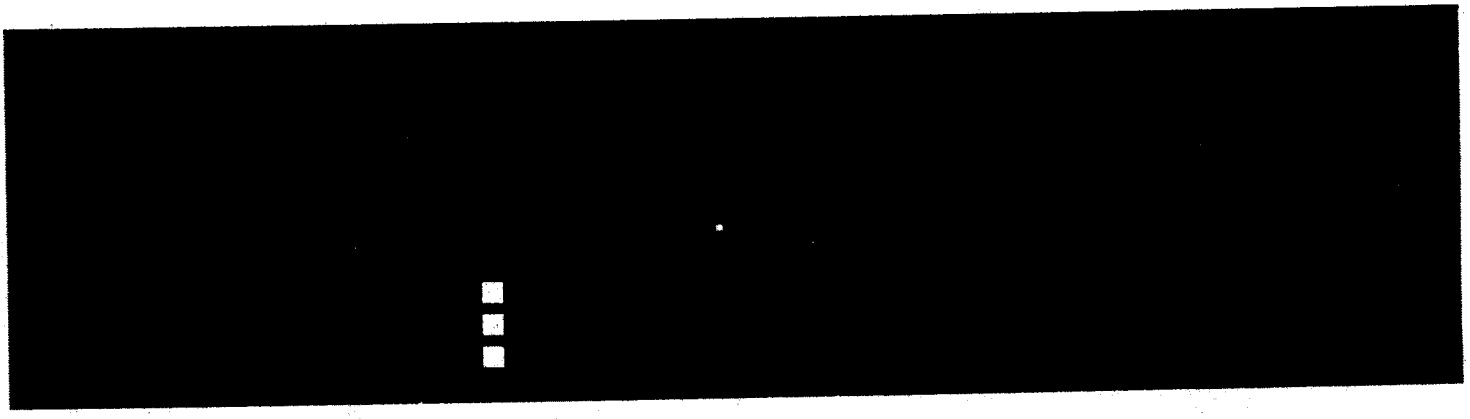
Diabetics: (most recent, if known) Blood Sugar Level (BSL)_____ Last A1C_____

Family Health History: ***Please circle conditions that run in your family. Indicate Father Mother Brother Sister Son Daughter***

General Health: **Diabetes I _____ Diabetes II _____ Hypertension _____ Cancer _____**

Eye Conditions: **Cataracts _____ Glaucoma _____ Macular Degeneration _____**

Cigarette Smoker ? ***Y / N***



Grays Harbor Vision Clinic, Inc.
301 N. Broadway • Aberdeen, Washington 98520
Phone (360) 533-1880

Member
American Optometric Association

Effective date of notice: April 14, 2003

NOTICE OF PRIVACY PRACTICES

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.

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.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS
The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, [we will] [we usually will not] ask you for special written permission.

[We will ask for special written permission in the following situations: _____.]

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION
In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;
- [specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.