



**Advanced Family Eyecare**

**Samuel C. Oliphant, O.D., F.A.A.O.**

14000 Quailbrook Dr., Oklahoma City, OK 73134  
(405) 751-7727 Fax (405) 755-1875

Please print in blue or black ink.

Chart # \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Preferred Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Email address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  M  F SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Legally Separated  Widowed

Spouse's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Race:  White  American Indian or Alaska Native  Asian  Black or African American  Hispanic  Native Hawaiian/  
other Pacific Island

Ethnicity:  Not Hispanic or Latino  Hispanic or Latino  Native Hawaiian/other Pacific Island

Preferred Language:  English  Spanish

Who may we thank for referring you to our practice? \_\_\_\_\_

May we use your name in thanking them?  Yes  No

Reason for today's visit: \_\_\_\_\_

Do you have any specific questions for your doctor today? \_\_\_\_\_

Are you planning on new eyeglasses today?  Yes  No  Maybe Are you planning on purchasing contacts?  Yes  No

If not a contact lens wearer, are you interested in trying contacts today?  Yes  No  Maybe

Are you interested in learning more about laser vision correction?  Yes  No

**Contact Lens History:**

Do you currently wear contact lenses?  Yes  No Hours per day: \_\_\_\_\_ Days per week: \_\_\_\_\_

Brand you are currently wearing? \_\_\_\_\_ Today's wearing time? \_\_\_\_\_ Age of current lenses? \_\_\_\_\_

What contact solution are you currently using? \_\_\_\_\_

**If not wearing contacts now, have you tried them in the past?**  Yes  No **Reason for discontinued wear?** \_\_\_\_\_

**Glasses History:**

Do you currently wear glasses?  Yes  No - If yes please select:  Full-time  Part-time Distance  Part-time Near

Glasses currently worn:  Single Vision  Bifocals  Progressive  Trifocals

How old were you when glasses were first prescribed? \_\_\_\_\_

Do you wear sunglasses?  Yes  No Are your sunglasses your most recent prescription?  Yes  No

Do you have any hobbies or jobs that require special glasses or contacts? \_\_\_\_\_

**Other Visual History:**

From whom did you receive your last eye examination \_\_\_\_\_ Date of last exam: \_\_\_\_\_

Why did you leave their practice? \_\_\_\_\_

Have you had any: Head Injuries?  Yes  No Head/Eye surgeries?  Yes  No

Illnesses involving eyes or head:  Yes  No

Do you have headaches?  Yes  No How often? \_\_\_\_\_ Location? \_\_\_\_\_

What relieves the headache? \_\_\_\_\_

Which describes your headache? (check all that apply)  Dull  Throbbing  Aching  Constant  Sharp  Other \_\_\_\_\_

**Social History:**

Use of Alcohol:  None  Social use only  1-2 drinks daily  Above average use  Alcohol dependence

Use of Tobacco:  None  Former Smoker  Light Smoker  Average Smoker  Heavy Smoker

Use of Narcotic:  None or Type & frequency: \_\_\_\_\_

Sexually Transmitted Disease:  Yes  No If yes, name kind of STD \_\_\_\_\_ HIV Positive?  Yes  No

**Family Members** (please list):

Name/Relationship to you	Age	Last Eye Exam	Name/Relationship to you	Age	Last Eye Exam

**Current Medications** (please list):

- 1. \_\_\_\_\_ for \_\_\_\_\_ 6. \_\_\_\_\_ for \_\_\_\_\_
- 2. \_\_\_\_\_ for \_\_\_\_\_ 7. \_\_\_\_\_ for \_\_\_\_\_
- 3. \_\_\_\_\_ for \_\_\_\_\_ 8. \_\_\_\_\_ for \_\_\_\_\_
- 4. \_\_\_\_\_ for \_\_\_\_\_ 9. \_\_\_\_\_ for \_\_\_\_\_
- 5. \_\_\_\_\_ for \_\_\_\_\_ 10. \_\_\_\_\_ for \_\_\_\_\_

Drug Allergies  Yes  No Please list: \_\_\_\_\_

**Ocular History**

Please list all ocular surgeries:

- Procedure: \_\_\_\_\_ Year: \_\_\_\_\_ Eye: R / L Doctor: \_\_\_\_\_
- Procedure: \_\_\_\_\_ Year: \_\_\_\_\_ Eye: R / L Doctor: \_\_\_\_\_
- Procedure: \_\_\_\_\_ Year: \_\_\_\_\_ Eye: R / L Doctor: \_\_\_\_\_

Current Eye Symptoms/Conditions: (check all that apply)

- Headaches  Excess Tearing/Watering  Blurred Distance Vision  Problems Driving at Night
- Glare/Light Sensitivity  Eye Pain/Soreness  Blurred Near Vision  Poor reading comprehension
- Tired Eyes  Sandy/Gritty Feeling  Fluctuating Vision  Head Tilt
- Amblyopia/Lazy Eye  Double Vision  Glaucoma  Fluorescent light sensitivity
- Burning  Mucous Discharge  Cataracts  Others (Please list): \_\_\_\_\_
- Dryness  Distorted Vision/Halos  Retinal Detachment \_\_\_\_\_
- Itching  Floaters  Macular Degeneration \_\_\_\_\_
- Redness  Flashes of light  Skipping lines when reading \_\_\_\_\_

**Medical History**

Indicate any personal history below: (check all that apply)

- Cardiovascular:**
  - Congestive Heart Failure
  - Elevated Cholesterol
  - High Blood Pressure
  - Stroke
- Integumentary:**
  - Acne Rosacea
  - Lupus
  - Psoriasis
  - Dizziness
- Musculoskeletal:**
  - Arthritis
  - Rheumatoid Arthritis
- Genitourinary:**
  - Menopause
  - Prostate Cancer
  - Cervical Cancer
  - Breast Cancer
- Endocrine:**
  - Diabetes
  - Gout
  - Thyroid (High or Low)
  - Renal Disease (Kidney)
- Hematologic/Lymphatic:**
  - Leukemia
  - Sickle Cell Disease
  - Temporal Arteritis
  - Lymphatic Disorder
- Neurological:**
  - Bell's Palsy
  - Brain Tumor
  - Multiple Sclerosis
  - Parkinson's Disease
  - Seizures
  - Psychiatric
- Head/ENT/Dental:**
  - Chronic Cough
  - Migraines
  - Sinusitis
  - Dizziness
- Gastrointestinal:**
  - Cancer: Colon, Liver
  - Colitis
  - Hepatitis
  - Inflammatory Bowel Disease
  - GERD (Acid Reflux)
- Immunologic:**
  - AIDS
  - Sarcoidosis
  - Sjogren's Syndrome
  - Syphilis
  - Tuberculosis
- Alzheimer's:**
  - Bipolar Disorder
  - Depression
  - Learning Disability
  - Schizophrenia
  - Anxiety Disorder
- Respiratory:**
  - Asthma
  - COPD
  - Emphysema
  - Lung Disorder
  - Lung Cancer

**Family Physician:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Last Physical Exam: \_\_\_\_\_

**Family History:**

<i>Condition</i>	<i>Relationship to Patient</i>	<i>Condition</i>	<i>Relationship to patient</i>
<input type="checkbox"/> Amblyopia/Lazy Eye	_____	<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Blindness	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Cataracts	_____	<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Retinal Detachment	_____	<input type="checkbox"/> Thyroid Disease	_____
<input type="checkbox"/> Macular Degeneration	_____	<input type="checkbox"/> Other	_____

**Other Information:**

*Would you like more information concerning the following?*

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Contact Lenses                         | <input type="checkbox"/> Integrated Learning         | <input type="checkbox"/> Occupational Lenses/Frames |
| <input type="checkbox"/> Visually Related Learning Disabilities | <input type="checkbox"/> Sports Lenses/Frames        | <input type="checkbox"/> Lazy/Crossed Eyed Therapy  |
| <input type="checkbox"/> Lens/Frame Advances                    | <input type="checkbox"/> Vision and Reading Problems | <input type="checkbox"/> Dry Eye Treatment          |
| <input type="checkbox"/> Computer Vision Syndrome               | <input type="checkbox"/> Laser Correction            | <input type="checkbox"/> Infant Visual Care         |
| <input type="checkbox"/> Sports Vision                          | <input type="checkbox"/> Lectures/Workshops          | <input type="checkbox"/> Vision Therapy             |

Activities/Hobbies (check all that apply):

- |                                       |                                       |  |                                       |
|---------------------------------------|---------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Baseball     | <input type="checkbox"/> Fishing      | <input type="checkbox"/> Needlepoint   | <input type="checkbox"/> Softball     |
| <input type="checkbox"/> Basketball   | <input type="checkbox"/> Gardening    | <input type="checkbox"/> Painting      | <input type="checkbox"/> Swimming     |
| <input type="checkbox"/> Boating      | <input type="checkbox"/> Golf         | <input type="checkbox"/> Racquetball   | <input type="checkbox"/> Television   |
| <input type="checkbox"/> Card Playing | <input type="checkbox"/> Handball     | <input type="checkbox"/> Reading       | <input type="checkbox"/> Tennis       |
| <input type="checkbox"/> Carpentry    | <input type="checkbox"/> Hunting      | <input type="checkbox"/> Repair (Home) | <input type="checkbox"/> Water Skiing |
| <input type="checkbox"/> Crafts       | <input type="checkbox"/> Knitting     | <input type="checkbox"/> Sewing        | <input type="checkbox"/> Whittling    |
| <input type="checkbox"/> Computers    | <input type="checkbox"/> Model Making | <input type="checkbox"/> Shooting      | <input type="checkbox"/> Woodworking  |
| <input type="checkbox"/> Drawing      | <input type="checkbox"/> Nature Study | <input type="checkbox"/> Snow Skiing   | <input type="checkbox"/> Other        |

Has your vision been a problem for you in any sport or hobby? \_\_\_\_\_

*Thank you for completing the above questionnaire. A comprehensive history allows us to better meet your needs.*

**After completion, please fax form to (405) 755-1875 or email to info@afeyecare.com.**

**Payment Policy**

1. Payment: Payment is expected at the time services are received.
2. Credit: Our office accepts Visa, MasterCard, American Express, Discover, and Care Credit
3. Insurance: We are not participating providers for any insurance companies. Therefore, payment is required to us at the time of service, and we will provide you the necessary paperwork for you to file your own insurance claim if you choose to do so. Your insurance company will reimburse you directly for the portion they are contracted to pay, *which may not be the full amount of the examination.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Performance Summary

## Advanced Family Eyecare

14000 Quailbrook Dr.

OKC, OK 73134

(405) 751-7727

www.afeyecare.com

After you consider each question, mark the column that applies.

	Never	Seldom	Occasional	Frequent	Always
<i>Blur when looking at near</i>	0	1	2	3	4
<i>Double vision, doubled or overlapping words on page</i>	0	1	2	3	4
<i>Headaches while or after doing near vision work</i>	0	1	2	3	4
<i>Words appear to run together when reading</i>	0	1	2	3	4
<i>Burning, itching or watery eyes</i>	0	1	2	3	4
<i>Falls asleep when reading</i>	0	1	2	3	4
<i>Seeing and visual work is worse at the end of the day</i>	0	1	2	3	4
<i>Skips or repeats lines while reading</i>	0	1	2	3	4
<i>Dizziness or nausea when doing near work</i>	0	1	2	3	4
<i>Head tilts or one eye is closed or covered while reading</i>	0	1	2	3	4
<i>Difficulty copying from the chalkboard</i>	0	1	2	3	4
<i>Avoids doing near vision work such as reading</i>	0	1	2	3	4
<i>Omits (drops out) small words while reading</i>	0	1	2	3	4
<i>Writes up or down hill</i>	0	1	2	3	4
<i>Misaligns digits or columns of numbers</i>	0	1	2	3	4
<i>Reading comprehension low, or declines as day wears on</i>	0	1	2	3	4
<i>Poor, inconsistent performance in sports</i>	0	1	2	3	4
<i>Holds books too close, leans too close to computer screen</i>	0	1	2	3	4
<i>Trouble keeping attention centered on reading</i>	0	1	2	3	4
<i>Difficulty completing assignments on time</i>	0	1	2	3	4
<i>First response is "I can't" before trying</i>	0	1	2	3	4
<i>Avoids sports and games</i>	0	1	2	3	4
<i>Poor hand/eye coordination, such as poor handwriting</i>	0	1	2	3	4
<i>Does not judge distances accurately</i>	0	1	2	3	4
<i>Clumsy, accident prone, knocks things over</i>	0	1	2	3	4
<i>Does not use or plan his/her time well</i>	0	1	2	3	4
<i>Does not count or make change well</i>	0	1	2	3	4
<i>Loses belongings and things</i>	0	1	2	3	4
<i>Car or motion sickness</i>	0	1	2	3	4
<i>Forgetful, poor memory</i>	0	1	2	3	4

Normal Score.....0-19

Suspect Problems..... 20-24

Examination Needed.....25 or Greater

**NOTICE OF PRIVACY PRACTICES**

## **Advanced Family Eyecare**

*Vision Source !*

**14000 Quailbrook Drive  
Oklahoma City, OK 73134  
Office (405) 751-7727  
Fax (405) 755-1875  
Web: [www.afeyecare.com](http://www.afeyecare.com)**

THIS NOTICE DESCRIBED HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

(Revised 7-2013)

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 issues. 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 medication and sending 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. Example of how we use or disclose your health information for payment purposes are: asking you about you health or vision care plan, or other source of payment; preparing and sending bills or claims; and collecting unpaid balances (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.

### **USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION**

In some limited situations, that 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 notice to and from the Federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims of suspected abuse, neglect, of domestic violence,
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audit by Medicare or Medicaid; for investigation of possible violations of health care laws;
- Disclosures for judicial and administrative proceeding, 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 or 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 purpose; or for the evaluation and health of members of the foreign service;
- Disclosure of de-identified information; unidentified
- Disclosure 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;
- 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.

## **APPOINTMENT REMINDERS**

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/ or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

## **OTHER USES AND DISCLOSURES**

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form". The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person at the beginning of this notice.

We will not use or disclose any protected health information for marketing purposes or disclosures that constitute a sale of protected health information without your consent. Additionally, any other uses and disclosures not described in this notice will be made only with your authorization.

## **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purpose of treatment (except emergency treatment), and payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E-mail to your personal E-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off- site). You may

have to pay for photocopies in advance. If we deny your request we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have a 30 day extension of time for us to give you access or photocopies of your health information. Send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this Notice.

- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree we will amend the information within 60 days of your request. We will send the corrected information to persons we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position that we will include with your health information along with any rebuttal statement. We will send this with your health information whenever a permitted disclosure is requested/ needed. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. IF you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax, or E-mail shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want).By law, the list will not include: disclosure for purposes of treatment payment or health care operations; disclosures for authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it. By law we can have a 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E- mail shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. Does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax, or E-mail shown at the beginning of the Notice.
- You may restrict certain disclosures of protected health information to a health plan when you pay out of pocket in full for the health care item or service.
- In the event that there is a breach of unsecured protected health information, you will be notified by our office within 30 days of the breach.

## 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 may generate in the future. If we change our Notice of Privacy Practice, we will post the new notice in our office, have copies available in our office, and post it on our Website.

## 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.

## ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Advanced Family Eye Care Your *Vision Source!* Notice of Privacy Practices.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Authorization for Release of Information

I hereby request the disclosure of information from my record.

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Phone: (\_\_\_\_\_) \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

The information is to be released **TO/FROM:**

Name/Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Phone: (\_\_\_\_\_) \_\_\_\_\_  
Fax: (\_\_\_\_\_) \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Contact Person(s): \_\_\_\_\_

The information is to be released by mail, phone, email, or fax **TO/FROM:**

**Advanced Family Eyecare  
14000 Quailbrook Dr.  
Oklahoma City, OK 73134  
(405) 751-7727/ fax (405) 755-1875**

The information to be released is as follows:

- Any information contained in the patient's record
- Only information related to the patient's educational success (Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date authorized.
- I understand that the recipient of the disclosed protected health information may not have any legal obligation to maintain the further confidentiality of the protected health information.
- We cannot refuse to treat you if you choose not to sign this form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient, Parent, or Legal Guardian)