Patient Information and History

(LAST NAME)	(FIRST NAME)	(M/F)	(BIRTH DATE)
(ADDRESS)		(CITY/STATE/ZIP)	
(PRIMARY PHONE NO) CIRCLE: CELL/HOME/WORK	(SECONDARY PHONE NO.) CELL/HOME/WORK	(OCCUPATION)	
(EMAIL ADDRESS)		(EMPLOYERS NAME)	
(TYPE OF VISION INSURANCE)	(NAME OF POLICY HOLDER - VISION)	(SOCIAL SECURITY NO. OF POLICY HOLDER - VISION)	
(ADDRESS OF INSURED IF DIFFERENT FROM PATIENT)			(INSURED DATE OF BIRTH)
(TYPE OF MEDICAL INSURANCE)	(NAME OF POLICY HOLDER – MEDICAL)	(SOCIAL SECURITY NO. OF POLICY HOLDER - MEDICAL)	
(ADDRESS OF INSURED IF DIFFERENT FROM PATIENT)			(INSURED DATE OF BIRTH)

I understand and agree that I am financially responsible for any portion of my exam that is not covered by my insurance and will pay the balance at the time of service. I have read all the information on the form and have completed it to the best of my knowledge. I will notify you with any changes to the above information.

Signature____

Patient or Guardian Date

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1. Age of Present Glasses _______________ Last Exam Date ___________________from Dr. _________________
2. Have you ever seen one of our Doctors before? _____ Yes ______ No If yes, who? Dr. Frank Dr. Joe Dr. Theresa
3. Type of examination today: _______ Spectacle ________ Contact Lens _________ Laser Surgery
4. Do you wear contact lenses? _____ Yes _____ No type (circle) Hard Gas Perm Soft Extended Wear Toric Bifocal
5. Would you like information regarding Laser Surgery? _____Yes _____ No
6. How many hours are you on a computer? ________hours How many hours on a tablet or cell phone? _______ hours
7. Hobbies or Special Visual Needs: ____
8. Are you currently pregnant? ______ Yes ______ No
9. Are you currently experiencing any of the following? (mark all that apply)

☐ Blurred Vision ☐ Headaches ☐ Flashing Lights ☐ Floating Spots
☐ Dryness ☐ Itching ☐ Eye Pain ☐ Trouble with night vision
☐ Blind Spots ☐ Trouble with bright lights ☐ Contact lens discomfort ☐ Other: ________________

10. Do you have **OR** have you had in the past any of the following ocular conditions? (please describe below)

☐ Glaucoma ☐ Macular Degeneration ☐ Double Vision ☐ Retinal Detachment/Tear
☐ Keratoconus ☐ Strabismus (Eye Turn) ☐ Amblyopia ☐ Cataracts
☐ Iritis ☐ Eye Surgery ☐ Eye Infection ☐ Herpes Simplex/Zoster
☐ Eye Injury ☐ Other(s)____

11. Please explain any checked items:

MEDICAL HISTORY: Check all that apply. **M = mother** **F = father** **GM = grandmother** **GF = grandfather**

	ME	Family	M-F-GM-GF		Me	Family	M-F-GM-GF		Me	Family	M-F-GM-GF
Cancer	☐	☐	________	**GASTROINTESTINAL**				**INTEGUMENTARY**			
CARDIOVASCULAR				Acid Reflux	☐	☐	________	Rosacea	☐	☐	________
Hypertension	☐	☐	________	Crohn's	☐	☐	________	Other	☐	☐	________
High Cholesterol	☐	☐	________	Other	☐	☐	________	**NEUROLOGIC**			
Heart Disease	☐	☐	________	**GENITOURINARY**				Headache	☐	☐	________
Other	☐	☐	________	Prostate	☐	☐	________	Migraine	☐	☐	________
CONSTITUTIONAL				STD	☐	☐	________	Other	☐	☐	________
Fatigue	☐	☐	________	Other	☐	☐	________	**PSYCHIATRIC**			
Other	☐	☐	________	**HEMATOLOGY**	☐	☐		Depression	☐	☐	________
ENT AND MOUTH				Anemia	☐	☐	________	Anxiety	☐	☐	________
Sinus Problems	☐	☐	________	Sickle Cell	☐	☐	________	Other	☐	☐	________
Other	☐	☐	________	Other	☐	☐	________	**RESPIRATORY**			
ENDOCRINE				**IMMUNE**				Asthma	☐	☐	________
Diabetes	☐	☐	________	HIV	☐	☐	________	COPD	☐	☐	________
Thyroid	☐	☐	________	Herpes	☐	☐	________	Other	☐	☐	________
Other	☐	☐	________	Sarcoidosis	☐	☐	________	**EYES**			
MUSCULOSKELETAL				Lupus	☐	☐	________	Glaucoma	☐	☐	________
Arthritis-Osteo	☐	☐	________	Arthritis-Rheumatoid	☐	☐	________	Mac.Degeneration	☐	☐	________
Other	☐	☐	________	Other	☐	☐	________	Other	☐	☐	________

Please list all *allergies* to medications, foods and environment: ____

Please list all *medications* that you are currently taking, prescribed or over the counter meds, vitamins and supplements:

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Notice of Privacy Practices and Patient Consent for Use and Disclosure of Protected Health Information

I understand…

- That under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information. Zaker Family Vision has a detailed document called the 'Notice of Privacy Practices'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.
- Zaker Family Vision's policy is to call patients by their first and/or last names unless written notification is given.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. If I ask, Zaker Family Vision, will provide me with the most current Notice of Privacy Practices. My signature means that I agree to allow Zaker Family Vision to use and disclose my protected health information to carry out treatment, payment, and healthcare operations, including release of medical information to my insurance/Medicare carrier to determine benefits payable for related services. Some routine eye-care costs (i.e. refractions) are generally not covered by insurance/Medicare. I understand that these costs are my responsibility. I have the right to revoke this consent in writing at any time, except to the extent that Zaker Family Vision has taken action relying on this consent.

____ _____________________________

SIGNATURE (Patient or Legal Custodian/Authorized Representative) DATE

_______________________________________ _____________________________

Print Name Relationship to Patient

Do you give permission to leave a detailed message on your answering machine and/or voicemail? YES or NO
(This would be the phone number recorded in the chart, unless another one is specified)

Do you give permission to discuss your health care issues with another designated person? YES or NO
(This includes allowing someone pick up a prescription, glasses or contact lenses, etc.)
If yes, please list additional designated individuals and their relationship to patient:

☐ Anyone who requests it
☐ Spouse ____ ☐ Parent(s) ____
☐ Children ____ ☐ Family Member(s)_____________________________________
☐ Friend(s) ____

*****Attention: If no block above is checked, no information will be given to anyone including letting someone pick up a prescription, glasses, contact lenses, etc.***