Dr. Richard A. Greene
Anastasia Eye Associates
Patient History and Information

Today's Date _____

Patient Name (First) _____ **(MI)** _____ **(Last)** _____

Prefer to be called? _____ **Reason for visit today?** _____

Address: _____ **City/State** _____ **Zip:**_____

Home Phone: _____ **Cell Phone:** _____

Male: _____ **Female:** _____ **Date of Birth:** _____/_____/_____ **Social Security #:** _____

Email address: _____ **Permission to use email?:**_____

Primary Care Physician: _____

Emergency Contact: _____ **Relationship:** _____

Phone # of Emergency Contact: _____

Pharmacy Name & Location: _____

Primary Insurance Company: _____

ID or Member #: _____ **Group #:**_____

Name of Primary Insured: _____ **Insured's DOB:** _____/_____/_____

Secondary Insurance Company (if applicable): _____

ID or Member #: _____ **Group #:**_____

Name of Primary Insured: _____ **Insured's DOB:** _____/_____/_____

CURRENT EYE SYMPTOMS

Last Vision Exam: _____

ASTHENOPIC			YES	NO	
YES	NO		_____	_____	Eye Pain/Soreness
_____	_____	Glare Sensitivity	_____	_____	Foreign Body
_____	_____	Headaches			Sensation
_____	_____	Light Sensitivity	_____	_____	Infection of Eyelid
_____	_____	Tired Eyes	_____	_____	Itching

PHYSIOLOGIC

_____	_____	Burning	_____	_____	Mucous
_____	_____	Dryness	_____	_____	Ptosis (drooping eyelid)
_____	_____	Eyelid Swelling	_____	_____	Redness
			_____	_____	Sandy or Gritty Feeling

CURRENT EYE SYMPTOMS (continued)

VISUAL SYMPTOMS			YES	NO	
YES	NO		_____	_____	Floaters or Spots
_____	_____	Blurred Vision Distance	_____	_____	Fluctuating Vision
_____	_____	Blurred Vision Near	_____	_____	Loss of Central Vision
_____	_____	Distorted Vision			
_____	_____	Double Vision	_____	_____	Loss of Side Vision
_____	_____	Flashes of Light	_____	_____	Loss of Vision

CURRENT EYE DISEASES

YES	NO		YES	NO	
_____	_____	Amblyopia	_____	_____	Glaucoma
_____	_____	Blepharitis	_____	_____	Glaucoma Suspect
_____	_____	Blindness	_____	_____	High Risk Meds
_____	_____	Cataracts	_____	_____	Macular Degeneration
_____	_____	Color Blindness	_____	_____	PVD (Floating Spots)
_____	_____	Diabetic Retinopathy	_____	_____	Retinal Detachment
_____	_____	Dry Eye	_____	_____	Strabismus
_____	_____	Eye Injuries			

PAST EYE SURGERIES (please include dates and surgeon's name)

_____

_____

_____

CURRENT MEDICATIONS

Name of Medication	For Treatment of?

ALLERGIES TO MEDICINES?

Name of Medication **Type of Reaction**

_____

_____

_____

HEALTH HISTORY

Last Health Exam: _____

YES	NO		YES	NO	
_____	_____	Fever	_____	_____	Rosacea
_____	_____	Fatigue	_____	_____	Shingles
			_____	_____	Skin Cancer
_____	_____	Hearing Loss			
_____	_____	Sinus Disorders			
			_____	_____	Multiple Sclerosis
_____	_____	Atrial Fibrillation	_____	_____	Frequent Headaches
_____	_____	Heart Disease	_____	_____	Convulsions/Seizures
_____	_____	Hypertension	_____	_____	Memory Loss
_____	_____	Stroke/TIA	_____	_____	Depression
_____	_____	Asthma	_____	_____	Diabetes
_____	_____	Emphysema (COPD)		What Type?:	_____
			_____	_____	Thyroid Disease
_____	_____	Flomax Use	_____	_____	Anemia
			_____	_____	Cholesterol
_____	_____	Arthritis	_____	_____	Seasonal Allergies
_____	_____	Muscle/Joint Pain	_____	_____	Lupus
_____	_____	Back Pain			
			_____	_____	Pregnant?
_____	_____	Herpes	_____	_____	Nursing?
_____	_____	Rash/Itching			
_____	_____	Other			

_____

FAMILY HISTORY

YES	NO	RELATIONSHIP	DISEASE
_____	_____	_____	Amblyopia (Lazy Eye)
_____	_____	_____	Blindness
_____	_____	_____	Cataracts
_____	_____	_____	Color Blindness
_____	_____	_____	Glaucoma
_____	_____	_____	Macular Degeneration
_____	_____	_____	Retinal Detachment
_____	_____	_____	Strabismus
_____	_____	_____	Arthritis
_____	_____	_____	Cancer
			Type:_____
_____	_____	_____	Diabetes
			Type:_____
_____	_____	_____	Heart Disease
_____	_____	_____	High Blood Pressure
_____	_____	_____	Kidney Disease
_____	_____	_____	Lupus
_____	_____	_____	Stroke
_____	_____	_____	Thyroid Disease
_____	_____	_____	Other: _____

CURRENT OCCUPATION:_____ YEARS?_____

EMPLOYER: _____

PLEASE ANSWER THE FOLLOWING:

YES	NO	
_____	_____	Do you drink alcohol? if yes, how much?
		____ occasional __ 1 per day ___2-3 per day
_____	_____	Do you smoke? if yes, how much
		____ occasional ___1/2 pack per day ___1 pack per day
		____ 1+ pack per day
_____	_____	If you do not smoke, did you ever?
		If a former smoker, when did you quit? _____

_____/_____/_____ _____

Date Signature of Patient

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing, we ***may not be allowed*** to process your insurance claims.

Date: _____/_____/_____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.**

_____ _____

Patient Name ***(PRINT)*** Patient ***(SIGNATURE)***

_____ _____

Legal Representative/Guardian ***(PRINT)*** Legal Representative/Guardian of Patient ***(SIGNATURE)***

_____

Relationship of Legal Representative/Guardian

Your comments regarding Acknowledgements or Consents:

_____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?

□ First Name Only □ Proper Sur Name □ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

□ Cell Phone Confirmation □ Home Phone Confirmation
□ Work Phone Confirmation ■ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

□ Cell Phone Confirmation □ Home Phone Confirmation
□ Work Phone Confirmation ■ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

DO NOT WRITE BELOW THIS LINE

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe)_____

_____ _____

Signature of Privacy Officer