



Confidential Patient
Questionnaire

Welcome to Eye 1st Vision & Laser. Please take your time to answer the following questions in full. When given a choice, please circle appropriate answer. In accordance with FTC Identity Theft Rule 16 CFR 681:2, please present a Photo ID with current address for photocopying. Additionally, for insurance purposes, we will need to make a copy of your medical and vision insurance card(s).

First Name _____ Middle Initial __ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Alternate Phone _____

E-Mail _____ Communication preference? Email; Mail; Phone

Date of Birth _____ Age _____ Sex: Male Female

Marital Status: Single Married Divorced Widow/Widower

Preferred Language: English; Spanish; Other _____

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

Ethnicity: Hispanic/Latino Native Hawaiian/other Pacific Islander
Not Hispanic/Latino

Employed? Yes No; Are you a Student? Yes No; If, Yes: Full Time Part Time

Medical Insurance Co: _____ ID#: _____

Primary Insured Name: _____ DOB: _____

Vision Insurance Co: _____ ID#: _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about Eye1st? Ins Co; Patient; Doctor; Yellow Pages; Search Engine; _____

NOTE: Please present your current Medical and/or Vision Insurance Cards

Health History

Patient Name _____ Sex: M F Age _____ Date _____

Do you wear glasses? NO YES If, YES (Please check all that apply)

All the time Distance Only Work/Safety Reading Computer Other _____
(RX Readers / Drugstore Readers?-circle one if applicable)

Have you ever worn contact lenses? YES NO Are you interested in wearing contact lenses? YES NO

Are you interested in LASIK? YES NO Do you work at a computer/video display terminal? YES NO

What hobbies or sports do you participate in? _____

Have you been diagnosed with or treated for any of the following? (explain):

Y	N		Y	N	
		Lung Disease/Asthma			High Cholesterol
		Kidney Disease			Seizures, Convulsions, Fainting
		Arthritis			Temporal Arteritis
		Diabetes. No. of years:			Carotid Artery Disease
		Neurological Disease			Pregnant or Nursing (currently)
		Migraines			Stroke
		Psychiatric Disorder			HIV/AIDS. No. of years:
		Nervous Disorder			Cancer
		Heart Disease			Suffering From Other Disease
		Gastrointestinal Disease. Type:			Do You Smoke? How much:
		High Blood Pressure. No. of years:			Do You Drink? How often:
		Scarring/Keloids			Allergic to Latex or Rubber
		Thyroid - Hyper / Hypo (circle)			Head or Spinal Injuries

Who is your medical doctor? _____

Please list all prescription and over the counter medications you are taking: _____

Please list all medication allergies _____

Have you been diagnosed with or treated for any of the following:

Y	N		Y	N	
		Cataracts			Corneal Disease
		Lazy Eye			Glaucoma
		Retinal Disease			Iritis
		Eye Injury			Other Eye Disorders:

Have you had Cataract Surgery?

Right Eye: NO YES: Surgery Date _____ Lens Implant: N Y **Left Eye:** NO YES: Surgery Date _____ Lens Implant:: N Y

Other Eye Surgery?

Right Eye: NO YES: Surgery Date _____ **Left Eye:** NO YES: Surgery Date _____

Has any family member (Mother, Father, Sisters, Brothers or Grandparents) been treated for the following:

Y	N		Y	N	
		Glaucoma			Retinal Detachment
		Cataracts			Corneal Disease
		Macular Degeneration			Retinitis Pegmentose
		Diabetic Retinopathy			Heart Disease
		Diabetes			Stroke
		Other Eye Problems:			Other Health Conditions:

Patient Signature _____ Date _____ Doctor Signature _____ Date _____

Dr. Dennis C. Matzkin Dr. George O. Waring, III Dr. James A. Stewart Dr. George D. Shida Dr. Julie A. Wolf



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.

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 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. Example 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 may further use or disclose your health information without your permission if required by law:

- 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;
- for disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- for 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;
- for disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- for 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;
- uses or disclosures for health related research;
- for uses and disclosures to prevent a serious threat to health or safety;
- for uses or disclosures for specialized government functions;
- for disclosures relating to worker's compensation program;
- for 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 that might help you.

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. If we ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization we cannot disclose health information. If you do sign, you may revoke it at any time. Revocations must be in writing to the office.

By sending a written request to the office you can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations;
- 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 Email to your personal Email address. We will accommodate these requests if they are reasonable;
- ask to see or to get photocopies of your health information. You will be able to review or have a copy of your health information within 30 days of asking us;
- ask us to amend your health information if you think that it is incorrect or incomplete;
- get additional paper copies of this Notice;

We reserve the right to change this Notice at any time as allowed by law.

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.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Eye1st Vision & Laser's Notice of Privacy Practices.

NAME: _____

DATE: _____

SIGNATURE: _____



Financial Responsibility Statement

➤ To our patients using their Medical Insurance Benefits:

We will be happy to help you file your insurance claim forms or take assignment on your vision benefits as designated by the third party plan of which you state you are a member. This service will be provided without additional charge to you. We will do all that we can to help you receive maximum benefits.

However, in the event that the Plan Sponsor determines that:

- 1) You are not eligible at the time of the claim;
- 2) You are eligible at the reduced level of coverage;
- 3) Insurance company fails to remit a payment on your behalf within 60 days of service;

I hereby agree to be financially responsible for any and all of the charges incurred by me and not paid by my insurance plan. Including, but not limited to co-payments, co-insurance, and deductibles. For reimbursement, I authorize my insurance plan to pay the provider directly.

➤ To our patients using their Medical or Vision Insurance Benefits:

I decline the option of using my insurance benefits for the services rendered today. I agree to pay for all fees at the time of service. My method of payment will be: (Please circle one)

Cash Check Credit Card Debit Card

3) I HAVE READ AND UNDERSTAND THE FINANCIAL RESPONSIBILITY POLICY.

Patient Signature

Date

At Eye1st Vision & Laser we give our patients the highest level of comprehensive eyecare using the latest equipment and technology available. This includes a thorough examination for eye diseases such as corneal disease, dry eye disease, glaucoma, cataracts, diabetic retinopathy, macular degeneration, and other retinal diseases. We perform a dilated internal ocular exam and utilize digital photography of the retina on every patient. Additionally, we perform a careful determination of vision correction (refraction).

In order to provide this level of care, all patients are charged a \$30 annual photography fee that will be collected on the date of the exam.

We thank you for choosing Eye1st Vision & Laser as your eyecare provider.

Signature

Date