Patient History Form Name: _____

PRIMARY CARE PHYSICIAN: _____ Date: _____

Physician's address: _____

City: _____State: _____ Zip: _____

Telephone: ( )_____

Did a physician refer you to our office? ____No ____Yes
Same as above or list below:
Physician's name: _____

Address: _____

City: _____State:_____ Zip:_____

I authorize Eye Care to leave messages on my (please check):
☐ Home phone:
( )_____
☐ Day/Work phone:
( ) _____
☐ Cell phone:
( )_____

PRESENT PROBLEM(S): What is the purpose of your visit today?_____

_____

PAST MEDICAL/SOCIAL HISTORY: Do you have any medical problems: Please circle and complete.

Diabetes Asthma Liver Disease Hayfever High Blood Pressure

Cancer (please specify type)_____

Do you have a pacemaker? ____No ____Yes

Do you have an artificial joint? ____No ____Yes

Do you have an artificial heart valve? ____No ____Yes

Do you have to take antibiotics before you go to the dentist? ____No ____Yes (why)_____

MEDICATIONS: Do you take any prescription or over-the-counter medications? ___No ___ Yes

Please list: (1)_____(2)_____(3)_____

(4)_____(5)_____(6)_____(7)_____

Are you allergic to any medications _____Yes (If Yes please list) _____

_____

Do you take blood thinners? ____No ____Yes (If Yes please list)_____

Have you taken any aspirin or aspirin product in the last 48 hours: _____No ____Yes

EYE HEALTH HISTORY:

Have you experienced any of these eye/health issues recently?

____Stinging	____Tearing	____Grittiness
____Dryness	____Glare	____Burning
____Occasional Blurred Vision	____Itching	____Trouble with night vision
____Light Sensitivity	____Double Vision	____Ocular Discomfort (aching)
____Eye Abrasion or Erosion	____Redness	____Decreased contact lens wearing time

FAMILY HISTORY: Are there any diseases that run in your family? _____Yes (please list)

_____

Do you or any of your blood relatives have :

cataracts ___No ___Yes (relationship)_____

Glaucoma ___No ___Yes (relationship)_____

Strabismus (eye turn) ___No ___Yes (relationship)_____

Amblyopia (lazy eye) ___No ___Yes (relationship)_____

Retinal disease ___No ___Yes (relationship)_____

Diabetes ___No ___Yes (relationship)_____

Blindness ___No ___Yes (relationship)_____

Keratoconus or other corneal disease ___No ___Yes (relationship)_____

How are you currently managing your vision condition:

____ Glasses ____Contacts ____ Both

Do you use any eye drops? (check all that apply)

____ Glaucoma ____ Allergy drops ____ Other _____

When was you last eye exam? _____

Have you had any surgery, injury or laser treatments to the eye? ____ No____ Yes (please describe below)

_____

_____

SOCIAL HISTORY: Do you smoke? ____No ____Yes

Do you drink alcohol beverages on a regular basis? ____No ____Yes

OCCUPATION: What kind of work to you do? _____

REVIEW OF SYSTEMS:

Do you have any current or past problems with any of the following? **Please describe.**

General Health ___No ___Yes_____

Eyes ___No ___Yes_____

Ears/Nose/Throat/Mouth ___No ___Yes_____

Heart ___No ___Yes_____

Liver ___No ___Yes_____

Lungs ___No ___Yes_____

Stomach/Bowel ___No ___Yes_____

Kidneys ___No ___Yes_____

Headaches/Seizures ___No ___Yes_____

Psychological disorder ___No ___Yes_____

Thyroid/Diabetes ___No ___Yes_____

Blood/Bleeding disorder ___No ___Yes_____

Females: Are you pregnant? ___No ___Yes_____

Planning to become pregnant? ___No ___Yes_____

INTEREST IN LASIK

Rate your satisfaction of your current glasses/contacts

____Extremely Satisfied ____Very ____Somewhat ____Not very ____Not at all

What activities or hobbies would you enjoy more without dependency of glasses/contacts?

_____

What is your biggest concern about having LASIK?

_____

I authorize Campen Eye Care to release Medical information to the referring physicians.

_____ _____ _____

Patient's signature Today's Date Physician's Signature

I authorize Campen Eye Care to release Medical information to the following family members or friends on my behalf:

(1)_____ _____ **(2)**_____ _____

Name printed Relationship Name Printed Relationship

(3)_____ _____ **(4)**_____ _____

Name printed Relationship Name printed Relationship

_____ _____

Patient's Signature Date

PATIENT INFORMATION: **DATE:**_____/_____/_____ **CAMPEN EYE CARE**

Patient Name:_____ ☐Male ☐Female
First **Middle** **Last**

Date of Birth: _____/_____/_____ **Social Security Number:** _____/_____/_____ ☐Single ☐Married ☐Divorced ☐Widowed

Student: ☐ Full time ☐ Part-time

Address:_____

_____

City_____**State**_____**Zip**_____

Mailing Address:_____

_____

City_____**State**_____**Zip**_____

Home phone: ( )_____

Cell phone: ( )_____

Work phone: ( )_____

Employer:_____
Occupation_____

Referred by:_____
Phone ( )_____

Emergency Contact:_____

Phone ( )_____, ( )_____

Relationship to patient:_____

Medical/Family Physician_____

Address:_____

Phone: ( )_____

INSURANCE INFORMATION:

Primary Insurance:_____

Policy holder:_____

Policy Holder's Date of Birth _____/_____/_____

Policy Holder's Social Security Number _____/_____/_____
Patient's Relationship to Policy Holder: _____

Secondary Insurance:_____

Policy Holder:_____

Policy Holder's Date of Birth _____/_____/_____

Policy Holder's Social Security Number_____/_____/_____
Patient's relationship to Policy Holder: _____

For Tricare Recipients: **(Please check the program that you are in)** **Sponsor Retired** ☐ **Yes** ☐ **No**

☐ **Tricare Prime** ☐ **Tricare Extra** ☐ **Tricare Standard** ☐ **Tricare for Life** **Patient's Relationship to Sponsor**_____

Sponsor Name _____ **Sponsor SS#:** _____/_____/_____ **Sponsor's Grade**_____

Sponsor Date of Birth: _____/_____/_____ **Effective Date:** _____/_____/_____ **Expiration Date:** _____/_____/_____

Notice to Patient: By signing this form, you grant us consent to treat you and to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Our Notice of Privacy Practices provides details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it. It provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our Notice of Privacy Practices, we reserve the right to change our privacy practices. If we do so, we will issue a revised Notice. Since revision may apply to your health care information, you have a right to receive a copy by contacting our privacy office.

You have the right to revoke your consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon consent. You should also understand that if you revoke this consent we might decline to treat you.

You are entitled to a copy of this Consent Form after you have signed it.

Patient's signature:_____ **Date:** _____/_____/_____
Or Signature of Patient's Representative

Printed name of Patient's Representative: _____

Campen Eye Care, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on November 1, 2010 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and he new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Samantha Mascunana. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary need to know" standards that limit various staff members' access to your health information according to their primary job junctions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under he custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $.50 for each page and the staff time charged will be $15.00 per hour including the time required to locate and copy your health information. If you want the copies mailed to you postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergencies). Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights or if you disagree with a decision we made regarding your access to your health information you can complain to us – in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: Campen Eye Care, LLC
Privacy Officer: Samantha Mascunana
Telephone: 912-927-8944
Fax: 912-355-7473
Address: 5102 Paulsen St., Unit 5
Savannah, GA 31405

HIPAA Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state law.