WELCOME TO ADVANCED FAMILY EYE CARE

Patient Name:_____ **Today's date:**_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

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

Home Phone:_____/ **Cell phone:**_____

Work Phone:_____ **Email:**_____

If patient is a minor; responsible party name :_____
Relationship: _____

INSURANCE INFORMATION

MEDICAL :
Primary Insurance : _____
Policy holder's name_____ ***Date of Birth:***_____
Policy holder's social security # _____

Secondary Insurance : _____
Policy holder's name_____ ***Date of Birth:***_____
Policy holder's social security # _____

Do you have VISION insurance? EYEMED (__) VSP (__) DAVIS (__) OTHER (__)

VISION:

Policy holder's name: _____
Policy holder's social security # : _____

HIPAA

I have reviewed or received a copy of Advanced Family Eye Care's Health insurance Portability Accountability Act. (HIPAA). By signing below I authorize the disclosure of my health information as described in the form.

Signature:_____ ***Date:***_____
Signature:_____ ***Date:***_____
Signature:_____ ***Date:***_____
Signature:_____ ***Date:***_____
Signature:_____ ***Date:***_____

Past Medical History: (Mark any of the conditions that you currently have or have a history of and in the space provided please describe and indicate how long you have had this problem)

☐ **None**

Diabetes: ☐ Y ☐ N (☐ insulin / ☐ no insulin) Year Diagnosed _____ Last A1C _____

Allergies:	☐ Y ☐ N _____	**Osteoporosis:**	☐ Y ☐ N _____
Alzheimer's/Dementia:	☐ Y ☐ N _____	**Night Sweats:**	☐ Y ☐ N _____
Anemia/Bleeding Problems:	☐ Y ☐ N _____	**Heart Problems/CVD :**	☐ Y ☐ N _____
Arthritis (Osteo, Rheumatoid):	☐ Y ☐ N _____	**Hepatitis A, B, C:**	☐ Y ☐ N _____
Asthma/ Bronchitis:	☐ Y ☐ N _____	**High Blood Pressure:**	☐ Y ☐ N _____
Blindness:	☐ Y ☐ N _____	**High Cholesterol:**	☐ Y ☐ N _____
Blood Transfusion:	☐ Y ☐ N _____	**HIV /AIDS :**	☐ Y ☐ N _____
Cancer:	☐ Y ☐ N _____	**Lupus:**	☐ Y ☐ N _____
Depression:	☐ Y ☐ N _____	**Migraine:**	☐ Y ☐ N _____
Emphysema/ COPD:	☐ Y ☐ N _____	**Sickle Cell Anemia:**	☐ Y ☐ N _____
Epilepsy/Seizures:	☐ Y ☐ N _____	**Stroke :**	☐ Y ☐ N _____
Glaucoma:	☐ Y ☐ N _____	**Thyroid Disease:**	☐ Y ☐ N _____
Kidney/Urinary Problems:	☐ Y ☐ N _____	**Tuberculosis(TB):**	☐ Y ☐ N _____
Ulcer/Stomach Problems:	☐ Y ☐ N _____	**Other:**	☐ Y ☐ N _____

Family Medical History: (In the space provided please indicate relationship. For example "maternal grandmother", "paternal grandfather" or "brother" ect.)

Anemia:	☐ Y ☐ N _____	**Heart Problems/Disease:**	☐ Y ☐ N _____
Arthritis:	☐ Y ☐ N _____	**Hepatitis:**	☐ Y ☐ N _____
Bleeding Problems:	☐ Y ☐ N _____	**High Blood Pressure:**	☐ Y ☐ N _____
Blindness:	☐ Y ☐ N _____	**Macular Degeneration:**	☐ Y ☐ N _____
Cancer:	☐ Y ☐ N _____	**Migraine/ Headaches:**	☐ Y ☐ N _____
Cataract:	☐ Y ☐ N _____	**Retinal Detachment:**	☐ Y ☐ N _____
Corneal Problems:	☐ Y ☐ N _____	**Sickle Cell:**	☐ Y ☐ N _____
Diabetes:	☐ Y ☐ N _____	**Stroke:**	☐ Y ☐ N _____
Emphysema:	☐ Y ☐ N _____	**Thyroid Disease:**	☐ Y ☐ N _____
Epilepsy/Seizures:	☐ Y ☐ N _____	**Tuberculosis (TB):**	☐ Y ☐ N _____
Glaucoma:	☐ Y ☐ N _____	**Other :**	☐ Y ☐ N _____

Last Name: _____ **First:** _____ **Age:**_____ **Sex:** _____
Date:_____ **Referred By:**_____ **Occupation:**_____

PATIENT HISTORY QUESTIONNAIRE

All information is strictly confidential and will be released only with written permission.

Current Medications: (Please list any medications including eye drops/ supplements/vitamins that you take.)
☐ None

Name of Medications Eye Drops/Supplement/Vitamin	Dose (How much per day)	Name of Doctor Prescribing

Drug Allergies with reactions:

_____
_____
_____
_____
_____

Social History:

Tobacco ☐ No ☐ Yes (including smokeless tobacco)
How many per day:_____ How long: _____
Have you used tobacco in the past? ☐ No ☐ Yes Approx. date started _____ Date stopped:_____
Alcohol ☐ No ☐ Yes
Number per week: _____ Wine _____Beer _____ Hard Liquor _____
Recreational Drugs ☐ No ☐Yes
Ever used intravenous drugs ☐ No ☐ Yes Date last used:_____
Marital Status: Married _____ Divorced _____ Single _____ Widowed _____ Student _____
Children: ☐ No ☐ Yes
Number _____
Hobbies/ Special Interests: _____

Reason for Visit: (Please explain the problems that bring you to our office today.)

Surgical History:

Eye Surgeries/Laser Treatments ☐ **None**
Type of Operation: Date: Complications:

All Other Surgeries ☐ **None**
Type of Operation: Date: Complications:

Lab Testing/Studies: Date Location Phone# (*if known*)

Blood Work:

X-Ray:

CAT Scan:

MRI:

Other:

Physician(s): Please give the name, address and phone numbers of any doctors you are currently seeing. If more space is needed, please use back of questionnaire.

Advanced Family Eye Care
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Naugatuck , CT 06770
203-729-6178

HIPAA
PATIENT CONSENT FORM

In the course of providing a service, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and conduct health care operations in our office.

We have a comprehension Notice of Privacy Practices that describes theses uses and disclosures in detail. You are free to refer to this notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary and appropriate for you to receive follow up care from another professional. Similarly, the use and disclosure of your health information for purposes of payments includes our submission of your health information to a billing agent or vendor of processing claim review, determination of benefits and payment, our submission of your health information to auditors hired by a third party payer and /or insurer, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get a copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services or per formed health care operations in reliance upon ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the use and disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggestions or restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

Patient name_____Date:_____

Patient Signature:_____