# Paul G. Hayter, O.D., P.C.

Address me by **Preferred language:** ☐ **English** ☐ **Spanish**

**Patient's Name:** _____

**Date of Birth:** _____/_____/_____ **SSN:** _____-_____-_____ Gender

**Address:** _____

**Apartment:** _____ **City:**_____ **State:**_____ **Zip Code:**_____

**Email Address:**_____

**Home Phone:** (_____)_____-_____ **Cell Phone:** (_____)_____-_____

**Primary Care Physician:** _____**Phone:** (_____)_____-_____

**Previous Eye Doctor:** _____ **Phone:** (_____)_____-_____

**Last Eye Exam:** _____/_____/_____ **Race:** Race/ Ethnicity Race/ Ethnicity

Race/ Ethnicity Race/ Ethnicity

**Vision Insurance Information:**

Insurance Name_____I.D.#_____

Relationship to Insured (circle one) ☐ Self ☐ Child ☐ Spouse ☐ Other (If self you may skip any duplicate information)

Primary Insured's Name_____

Date of Birth _____/_____/_____ Employer _____

**Medical Insurance Information:** **(Benefits for your vision exam may be better through your medical insurance. This is also who would cover for treatment or tests for eye diseases and injuries)**

Insurance_____

I.D.#_____ Group #_____

Relationship to Insured (circle one) ☐ Self ☐ Child ☐ Spouse ☐ Other ☐ Same as above

Primary Insured's Name_____

Date of Birth _____/_____/_____ Employer _____

How did you hear about our office?

Other_____

**If you were referred by a friend or coworker what is their full name?**

_____

**If you refer a Non-Family member to our office you will receive a $25 credit to your account which can be used towards the purchase of glasses, sunglasses, contacts or your exam fee**

**I wear Glasses** ☐ **I currently wear contacts** ☐ **I would like to try contacts for the first time** ☐

**I have worn contacts in the past** ☐ **None of these apply to me** ☐

What brand of contact lens do you currently wear? _____

I wear: **Soft Lenses** ☐ **Toric/Astigmatism** ☐ **Multifocal** ☐ **Monovision** ☐ **Rigid Gas Permeable/Hard Lenses** ☐

**Medical History:**

Allergies to medications: _____

Medications currently taking **and DOSAGE/MG**:_____

_____

Any history of eye disease, injuries or surgeries?_____

**Family History:** Does anyone in the patient's family have any of the following? (living or deceased)

please include relation ie**. Maternal Grandmother, Paternal Grandfather, etc.**

| Disease/ Condition | No | Family Member Relationship to Patient | Disease/ Condition | No | Family Member Relationship to Patient |
|---|---|---|---|---|---|
| Blindness | ☐ | Relation to patient | Cancer | ☐ | Relation to patient |
| Cataracts | ☐ | Relation to patient | Diabetes | ☐ | Relation to patient |
| Macular Degeneration | ☐ | Relation to patient | Heart Disease | ☐ | Relation to patient |
| Glaucoma | ☐ | Relation to patient | High Blood Pressure | ☐ | Relation to patient |
| Retinal Detachment | ☐ | Relation to patient | Kidney Disease | ☐ | Relation to patient |
| Crossed Eyes | ☐ | Relation to patient | Arthritis | ☐ | Relation to patient |
| Lupus | ☐ | Relation to patient | Thyroid Disease | ☐ | Relation to patient |

**Other Conditon:**_____ Currently **Pregnant** or **Nursing**. Yes or no

**Has the patient ever been exposed to or infected with**

**Gonhorrhea?** Yes or no **Hepatitis?** Yes or no **Syphilis?** Yes or no **HIV?** Yes or no

**SOCIAL HISTORY: (CIRCLE YES or NO)**

Does the **patient drive**? Yes or no Any problems while driving? _____

**Use tobacco**? Yes or no Type/amount/how long _____

**Drink Alcohol**? Yes or no Type/amount/how long _____

**Use illegal drugs**? Yes or no Type/amount/how long_____

**Review of Symptoms. Please circle all that apply.**

| **Eyes** | **Constitutional** | **Allergic/ Immune** |
|---|---|---|
| Vision Loss ☐ | Fever ☐ | Drug Allergies ☐ |
| Blurry Vision ☐ | Weight Loss/ Gain ☐ | Seasonal Allergies ☐ |
| Distorted Vision ☐ | Fatigue ☐ | Lupus ☐ |
| Double Vision ☐ | Trauma ☐ | Arthritis ☐ |
| Dryness ☐ | **Integumentary / Skin** | **Lymphatic/Hematologic** |
| Redness ☐ | Eczema ☐ | Anemia ☐ |
| Mucous Discharge ☐ | Rosacea ☐ | Bleeding Problems ☐ |
| Gritty Feeling ☐ | Psoriasis ☐ | Leukemia ☐ |
| Itching ☐ | **Neurologic** | **Musculoskeletal** |
| Burning ☐ | Headaches ☐ | Fibromyalgia ☐ |
| Excess Watering ☐ | Migraines ☐ | Muscular Dystrophy ☐ |
| Light Sensitivity ☐ | Seizures ☐ | Osteoarthritis ☐ |
| Eye Pain / Soreness ☐ | Multiple Sclerosis ☐ | Ankylosing Spondylitis. ☐ |
| Chronic Infection ☐ | **Endocrine** | **Genitourinary** |
| Sties ☐ | Diabetes No Insulin ☐ | Kidney Problems ☐ |
| Flashes ☐ | Diabetes With Insulin ☐ | Bladder Problems ☐ |
| Floating Spots ☐ | Thyroid Dysfunction ☐ | STD's ☐ |
| Tired Eyes ☐ | **Respiratory** | **Other/ List Below** |
| Cataracts ☐ | Asthma ☐ | |
| Diabetic Retinopathy ☐ | Bronchitis ☐ | |
| Glaucoma ☐ | Emphysema ☐ | |
| Macular Degeneration ☐ | **Cardiovascular** | |
| Retinal Detachment ☐ | Heart Disease ☐ | |
| **Gastrointestinal** | Hypertension / High Blood Pressure ☐ | |
| Colitis ☐ | Hypercholesterolemia ☐ | |
| Crohn's Disease ☐ | **Ears/ Nose/ Throat** | |
| Ulcers ☐ | Allergies ☐ | |
| Constipation ☐ | Sinus Congestion ☐ | |
| Diarrhea ☐ | Runny Nose ☐ | |
| | Post Nasal Drip ☐ | |
| | Chronic Cough ☐ | |
| | Dry Throat/ Mouth ☐ | |

**Any other problem you would like the doctor to address today? Please list any problems or concerns you may have below:**

**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 read it carefully. The privacy of your health information is important to us.

**Our Legal Duty**: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We will use and communicate your health information only for the purpose of providing your treatment, obtaining payments and conducting health care operations.

**USES AND DISCLOSURES OF HEALTHCARE INFORMATION:**

**To Provide Treatment:** We will use and disclose your health information within our office to provide you with the best health care possible. This may include business office staff, assistants, opticians, physician assistants, nurses, and physicians. In addition, we may share our health information with referring physicians, laboratories, pharmacies, and other health care personnel providing you treatment, including contact lens and frame companies.

**To Obtain Payment:** We may use and disclose your health information to obtain payment for services, materials, and treatment you received in our office. We may do this with insurance forms filed for you by mail or send electronically.

**Healthcare Operations:** Your health information may be used during performance evaluation of our staff, training programs for students, interns, associates, and business and/or clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing or credentialing activities.

**Appointment Reminders:** Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time to contact us for an appointment. Additionally, we may contact you for follow up on your care and inform you of treatment options or services that may interest you or a family member. These may include postcards, folding cards, letters, telephone, voice mail, or email.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we believe a patient is a victim of abuse, neglect or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**Public Health and National Security:** We may disclose to Federal Officials or military authorities your health information required for lawful intelligence, counterintelligence, and other national security activities.

**Law Enforcement:** As permitted or required by State or Federal Law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

**Family, Friends, and Caregivers:** We may disclose your health information to a family member, friends, care giver, or other person who you tell us will be helping you with your home hygiene, treatment, medications, or payment. In case of an emergency, where you are unable to tell us what you want we will use our very professional judgment when sharing your health information. We will also use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, materials, or other similar forms of health information.

**To Coroners, Funeral Directors, and Medical Examiners:** We may be required by law to provide information about your health to coroners, funeral directors, and medical examiners for the purpose of determining a cause of death and preparing for a funeral.

**Required by Law:** We may use or disclose your health information when required to do so by law.

**Your Authorization:** Other than stated above or where Federal, State or Local Law requires us, we will not disclose your health information without your written authorization. You may revoke your authorization in writing at any time. Your revocation will not effect any use of disclosures permitted by your authorization while it was in effect.

**PATIENT RIGHTS:**

**Access:** You have the right to look or get copies of your health information, with limited exceptions (you must make a request in writing to obtain access to your health information). If you request copies, we will charge you a fee for each page, and per hour for staff time to locate, duplicate and assemble your copy, and postage if you request the copies to be mailed to you.

**Documentation of Health Information:** You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health care operations and certain other activities. Our documentation procedures will enable us to provide information form April 14, 2002 and forward. Please let us know in writing the time period for which you are interested. Your request must be limited to no more than six years at a time. We may charge you a reasonable fee for your request.

**Alternative Communications:** You have the right to request that we communicate with you about your health information by alternative means or to alternative location. ( You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location. We will make every effort to honor your reasonable request for confidential communications.

**Amendments:** You have the right to ask us to amend your health information. In order to standardize our process, please submit your request in writing and describe the reason for the change. Your request may be denied under certain circumstances.

**Request a Paper Copy of this Notice:** You have the right to obtain a copy of this Notice of Privacy Practices from our office at any time.

**Complaints:** 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 of Civil Rights. We support your right to the privacy of your health information. If you want more information please contact our office.

***I authorize the release of any information necessary to process claims with an insurance company and receive payment. I assume all financial responsibility for this account and all amounts due in the event of a denial by my insurance company. A predetermination of benefits made by myself or this office is never a guarantee of payment by an insurance company. I understand my rights under federal HIPPA (patient privacy) laws.***

**Sign**_____**Date**_____/_____/_____

**Print** _____

**Relationship (if signing for a minor)**_____