Central DuPage Vision Center Patient History

Today's Date _______________
Last Name ____ First Name ______________________________ MI ________
Address ___________________________________ City ___________________________ State _________ Zip ________
Home Phone ______________________ Cell Phone _______________________ Email _____________________________
Date of Birth ______________________ Age_______ Last four digits of Social Security # _____________________
Preferred language ____________________________ Preferred Communication ☐Mail ☐Email ☐Telephone
Race _________________________ Ethnicity ☐Hispanic ☐Non-Hispanic ☐Hawaiian ☐Pacific Islander ☐Other
Primary Reason for today's visit ____

Insurance
Insurance Company Name _______________________________ Group# ___________________________________
Member Name ____ Member Birthday ___________________________
Member # or ID _______________________________________ Marital Status ______________________________

Ocular Information
Last Eye Exam ____
Do you have any eye conditions or problems? □ No □ Yes (explain) ____
Have you had any eye surgeries? □ No □ Yes (explain) ____
Have you had any eye injuries? □ No □ Yes (explain) ____
Please check any of the following which apply to you

□ Retinal Detachment □ Cataracts □ Glaucoma □ Dry Eyes
□ Macular Degeneration □ Glasses □ Blurry Vision □ Computer Strain

Do you or have you ever worn contact lenses? □ No □ Yes (explain) ____
Are you interested in contact lenses or changing your current contact lenses? □ No □ Yes (explain) ______________
____

Medical Information
Primary Care Physician (Name/Phone) ____
Pharmacy (Name/Location) ____ Height ________ Weight ________
How is your general health? ____ Last Medical Exam ___________
Please check any of the following systems which you have had a problem with in the past or present?

□ Cardiovascular □ Genitourinary □ Allergic/Immunologic □ Neurological/Headaches
□ Endocrine (glands) □ Ear/Nose/Throat □ Integumentary (Skin) □ Psychiatric
□ Gastrointestinal □ Blood/Lymph □ Muscles/Bones □ Respiratory

Please explain any of the checked above ____
____
Do you have any allergies to medications □ No □ Yes (explain) ____
List any medications you take (including dose) ____
____
____
Have you ever been exposed or infected with the following? □ Gonorrhea □ Hepatitis □ HIV □ Syphilis
Tobacco use? □ Never □ Former □ Current (type/amount/how long) ______________________________
Alcohol use? □ No □ Yes (type/amount/how long) ____
Illegal drug use? □ No □ Yes (type/amount/how long) ____

Family History
Please include the relationship for any positive family history

High blood pressure? □ No □ Yes ______________ Macular degeneration? □ No □ Yes ______________
Diabetes? □ No □ Yes ______________ Retinal detachment? □ No □ Yes ______________
Thyroid disease? □ No □ Yes ______________ Glaucoma? □ No □ Yes ______________
Heart Disease? □ No □ Yes ______________ Blindness? □ No □ Yes ______________
Other? ____

PRIVACY POLICY

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. The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA" we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending your bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2013 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Patient Consent

I authorize my insurance benefits to be paid directly to Central DuPage Vision Center. I assume responsibility for any remaining balance not covered by insurance. I further authorize the diagnosis and treatment by the doctor, and the release of any medical information as necessary for proper care. I have read and understand the privacy policy of Central DuPage Vision Center.

I consent to the release of my medical information to the persons listed (include relationship):______________________
____

Patient Name (Print)____

Signature ____ **Date** ___________________