Visual Ophthalmology Services

6240 Forest Ave. Ridgewood, NY 11385
Phone:718-418-0100
Fax:718-418-0005

9402 57th Ave Elmhurst, NY 11373
Phone:718-271-4472
Fax:718-271-3011

Patient Information

***If you are a new patient, please fill out all the blanks**
***If you are a follow up please update any information that has changed**

Last Name: _____ First Name: _____

D.O.B. ____/____/_____

Phone# _____ Cell Phone#_____

Address: _____

City: _____ State: _____ Zip _____

Primary Doctor: _____

Primary Doctor Phone# _____

Pharmacy Name: _____

Pharmacy Phone# _____

Please print and sign your name next page

MEDICAL INFORMATION DISCLOSURE (HIPPA)

Effective April 14, 2003

Visual Ophthalmology oversees privacy matters in our office. You may contact him/her regarding any problems or concerns regarding your medical information and HIPPA questions.

Federal law provides that we may use your protected health information, without your specific authorization, for treatment of you (such as when speaking to a specialist who is on the case), for payment of services (such as filling out your insurance forms), or for health care operations (such as accounts Medicare audit, etc.). We may also disclose information when it's required by law; such as for public health purposes, child/elderly abuse, coroner/medical examiner, organ donation; funeral director, department of health or OPMC, judicial-administrative proceeding, law enforcement officials, or to avert serious health or safety threats. New York state law provides additional protection for information regarding HIV/AIDS, which will continue to respect.

We may contact you by mail or phone, at your residence or place of work to remind you of appointments or to provide information about you; unless you instruct us otherwise, we may leave a message for you on the answering machine device or with the person who answers the phone. You may make responsible requests, in writing for us to use alternate methods of communicating with you in a confidential matter. Other users or disclosures of your medical information will be made only with your written authorization. You have the right to revoke or revise any written authorization that you give.

You have the right to request restrictions on certain of the uses or disclosures described above; except as state below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charge). You have the right to request amendments to your medical information. Such request must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree; if we disagree; if we disagree we will further notify you of your rights. You have the right to request an accounting of any disclosures we make to you, or as permitted by law as stated above, or for those made before April 14, 2003.

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices. We are required to abide by the terms of this notice as long as it is in effect. We reserve the right to revise the notice; if so, you will be given a copy the new notice.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with this Office, or with the Secretary of the Department of Health and Human Services of the United States. No retaliatory action will be taken against you for any complain you may take.

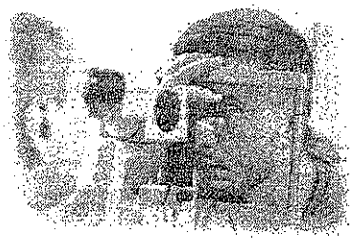
_____	_____	_____
Signature	**Name (print)**	**Date**

WELCOME TO VISUAL OPHTHALMOLOGY SERVICES

Medical History Questionnaire

NAME _____ Birth Date:_____

Gender: ☐Male ☐Female



Patient Notification

A Routine Eye Examination (covered by Vision Insurance Plans) covers a prescription to address the following vision conditions: Near-Sightedness, Far-Sightedness, Astigmatism and Presbyopia. All other causes of decreased vision as well as other problems and complaints (such as those listed below), may be billed medically after discussing them with the Doctor and result in higher fees.

Current Eye Symptoms - Are you **currently** experiencing any of the following:

Visual Symptoms		
Blurred Vision Distance	☐Yes	☐No
Blurred Vision Near	☐Yes	☐No
Distorted Vision	☐Yes	☐No
Double Vision	☐Yes	☐No
Flashes of lights	☐Yes	☐No
Floaters or Spots	☐Yes	☐No
Fluctuating Vision	☐Yes	☐No
Loss of Central Vision	☐Yes	☐No
Loss of Side Vision	☐Yes	☐No
Loss of Vision	☐Yes	☐No
Asthenopic		
Glare Sensitivity	☐Yes	☐No
Headaches	☐Yes	☐No
Light Sensitivity	☐Yes	☐No
Tired Eyes	☐Yes	☐No

Physiologic		
Burning	☐Yes	☐No
Dryness	☐Yes	☐No
Epiphora (Watery Eyes)	☐Yes	☐No
Eyelid Swelling	☐Yes	☐No
Eye Pain or Soreness	☐Yes	☐No
Foreign Body Sensation	☐Yes	☐No
Infection of Eye Lid	☐Yes	☐No
Itching	☐Yes	☐No
Mucous	☐Yes	☐No
Ptosis (Droopy Eyelid)	☐Yes	☐No
Redness	☐Yes	☐No
Sandy or Gritty Feeling	☐Yes	☐No
Other (please specify)	☐Yes	☐No

_____

List any medications you take and dosages (including over-the-counter prescriptions, oral contraceptives, eye drops)

☐No Medications

_____

_____

Medical History: Please check all that apply to you

- ☐ Asthma
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy/seizures
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Psychiatric disease
- ☐ Stroke
- ☐ Thyroid
- ☐ None
- ☐ Other _____

Allergies: please list any allergies that you have_____

_____

Surgical history (including eye surgeries and laser procedures): Please list past surgeries with approximate date_____

_____

Family History: Do you know of any blood relative who has or had

Systemic diseases	Relationship to patient		
☐ Diabetes	_____	☐ Color blindness	_____
☐ High blood pressure	_____	☐ Cataract	_____
☐ Cancer	_____	☐ Glaucoma	_____
☐ Psychiatric Disease	_____	☐ Glaucoma suspect	_____
☐ Other diseases	_____	☐ Macular degeneration	_____
Eye diseases		☐ Retinal detachment	_____
☐ Lazy eye (Amblyopia)	_____	☐ Eye turn (Strabismus)	_____
☐ Blindness	_____	☐ Other eye conditions	_____

Social History: ***This information is kept strictly confidential. However you may discuss this portion directly with the doctor if you prefer.*** Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box ☐).

Do you drink alcohol? ☐Yes ☐No (☐ Beer ☐ Wine ☐ Liquor) If yes, how much/week? _____

Do you smoke? ☐Yes ☐No If yes, how many cigarettes/day? _____

Do you consume caffeine? ☐Yes ☐No If yes, how many cups/day? _____

Do you use recreation drugs? ☐Yes ☐No If yes, what type and frequency? _____

Are you on a special diet? ☐Yes ☐No If yes, please describe? _____

Review of Systems - Do you currently have any problems in the following areas (✓ check all that apply):

Constitutional
Fever
Fatigue
Other
Ear, Nose, Throat, Mouth
Hearing Loss
Sinus Disorders
Other
Cardiovascular
Atrial Fibrillation
Heart Disease
Hypertension
Stroke/TIA
Neurological
Convulsions/Seizure
Frequent Headaches
Multiple Sclerosis
Respiratory
Asthma
Emphysema/COPD
Shortness of breath
Other
Gastrointestinal
Intestinal Conditions
Other
Psychiatric
Memory Loss
Depression
Other
Endocrine
Diabetes
Thyroid Disease
Other
Blood
Anemia
Cholesterol
Allergic/Immunologic
Seasonal Allergies
Lupus
Other
Maternity
Pregnant
Nursing
Other Conditions
Urinary
Flomax Use
Kidney Disease
Urinary Conditions/Symptoms
Musculoskeletal
Arthritis
Muscle/Joint/Back Pain
Skin
Herpes
Rash/Itching
Rosacea
Shingles
Skin Cancer

Current Vision:

Your last eye exam, where_____

Do you wear glasses? ☐ Yes ☐ No. If yes, how old is your present pair? _____

Type off glasses: ☐Single vision ☐Bifocal ☐Progressive

Do you wear contact lenses? ☐ Yes ☐ No. If yes, how old is your present pair of lenses? _____

If no, are you interested in contact lenses? ☐ Yes ☐ No

Are you bothered by glare: ☐ Yes ☐ No

Are you sensitive in bright sunlight? ☐ Yes ☐ No

Please tell us how you learned about our office_____