PATIENT HEALTH HISTORY

Patient Name: _____ Date: ____/____/____ DOB: ____/____/____

Address: _____ City, State, Zip: _____ Gender: M F

Occupation: _____ Primary Care Physician: _____ Social Security Number: _____

IMPORTANT--Please Circle your preferred communication: Phone • Text message on cell phone • E-Mail

Email: _____ Home Phone: _____ Cell Phone: _____

Payment and Insurance information: No insurance / VSP / Care Credit / PHP / MES / EyeMed / Sierra Pacific Other _____

**** Please present your insurance cards to the front desk so that we can make a copy for billing purposes ****

May we ask how you were referred here? Prior patient • Yellow pages • Internet • Location • Friend / relative name _____

Please describe the main reason for your examination here today

_____

Location: Which eye / lid / other _____ What is severity? Mild / Moderate / Severe How long? _____

Circle other eye concerns: Burning / Crusting / Dryness / Itching / Light sensitivity / Pain / Pus or mucus / Redness / Tearing / Other

Explain these or other concerns: _____

List all your CURRENT MEDICATIONS • If you have a written list, you may present it instead

_____

_____

List any **allergic reactions** to medications or eye drops: _____

Briefly list major surgeries (include eye surgeries, Lasik, PRK): _____

Eye Disease/Condition	Yourself		Family Member		Relationship
	Yes	No		Yes	No	
Cataract (current or removed)	·	·	Blindness	·	·	_____
Eye Turn	·	·	Eye Turn	·	·	_____
Glaucoma	·	·	Glaucoma	·	·	_____
Macular Degeneration	·	·	Macular Degeneration	·	·	_____
Loss of peripheral vision	·	·	Retinal Detachment	·	·	_____

Other: _____

Review of Systems

Please indicate below if you have or ever had problems with the following conditions:

Allergic/Immunologic
- **None**
- Lupus (SLE)
- Rheumatoid Arthritis
- Environmental Allergies
- Seasonal Allergies
- Other (i.e., Latex)

Ear, Nose and Throat
- **None**
- Sinusitis
- Upper Respiratory Tract Infection
- Other _____

Gastrointestinal
- **None**
- Crohn's Disease
- Colitis
- Acid Reflux/Ulcer
- Other _____

Skin/Integumentary
- **None**
- Eczema
- Rosacea
- Psoriasis
- Other _____

Psychiatric
- **None**
- Depression
- Bi-Polar
- Schizophrenia
- Other _____

Cardiovascular
- **None**
- High Blood Pressure
- Heart Disease
- Stroke
- High Blood Cholesterol

Endocrine/Glands
- **None**
- Diabetes
- Hormone Dysfunction
- Thyroid Dysfunction
- Other _____

Respiratory
- **None**
- Asthma
- Bronchitis
- Emphysema
- Other _____

Muscle/Skeletal
- **None**
- Arthritis
- Fibromyalgia
- Ankylosing Spondylitis
- Other _____

Genital/Urinary
- **None**
- Urinary Tract Inf.
- HIV Positive
- Other _____

Hematologic/Lymphatic
- **None**
- Anemia
- Leukemia
- Bleeding Disorder
- Other _____

Neurological
- **None**
- Multiple Sclerosis
- Epilepsy
- Tremors
- Other _____

General Health
- **None**
- Weight loss/gain
- Fever
- Fatigue
- Other _____

Social
- Tobacco Use (circle one): Never Smoked / Current / Former Smoker
- Alcohol use: None / Occasional / Frequent
- Non-Prescription drug use: _____

_____

Signature: _____ Date: _____ Reviewed by Doctor's initials: _____

Patient or parent / guardian

Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I,_____ understand that as part of my healthcare, Enterprise Optometry, may originate and maintain paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care treatment,
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and eye care information to my bill,
- A means by which a third-party payer can identify that services billed were actually provided and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I further understand that Enterprise Optometry Group reserves the right to change their notice and practices prior to implementation, in accordance with section 164.506 of the Code of Federal Regulations. Should Enterprise Optometry Group change their notice, they will post a copy of any revised notice in their facilities.
I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of the organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses including disclosures via fax.

I authorize Enterprise Optometry to inquire about my account and to receive and information about any and all of my insurance or other insurance claims, assigned or non-assigned and I understand that I am fully responsible for charges incurred with this treatment even though the doctor files the insurance for me. I understand that any delinquent accounts are subject to collection and acknowledge responsibility.

Patient Signature _____
Parent Signature _____
Date _____

FOR OFFFICE USE ONLY
[ ] Consent received by _____ on _____
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to patients medical record on _____

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Notice of Privacy Practices

Effective date of notice: July 20, 2011

Enterprise Optometry Group
3080 Victor Ave.
Redding, Ca. 96002

530-222-3166
530-222-6539 fax

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

General Rule: Our legal obligation is to keep private health information that identifies you. The law obligates us to give you notice of our privacy practices. Without your written permission, we can use your health information only in our office or disclose it outside of our office for purposes of treatment, payment or healthcare operations. In most other situations we will not use or disclose your health information unless you sign a written authorization form. However, the law allows or requires us to disclose your health information without written authorization in some limited situations.

Uses or Disclosures of Health Information: Examples of how we use information for treatment purposes include setting up an appointment for you, testing your eyes, prescribing glasses or contact lenses, prescribing medication, selecting and ordering glasses or contact lenses.

We may disclose your health information outside our office for **treatment** purposes including referral to another doctor or clinic for eye care, sending a prescription for glasses or contacts to another professional to be filled, providing a prescription for medication to a pharmacist, and notifying you that your glasses or contact lenses are ready to be picked up. We may ask for copies of your health information from another professional that you may have seen before.

We may use your health information for **payment** purposes. Some examples would include asking you about your health and vision care plans, or about other sources of payment for services; preparing bills to send to you or your health or vision care plan; processing payment by credit card and collecting unpaid amounts due; sending bills or claims for payment to you or your health or vision plan; and asking a collection agency or attorney to help us with unpaid accounts. We will use and disclose your health information for **healthcare operations.** These include those administrative, evaluative and training functions that allow us to run our office including financial or billing audits, internal quality assurance, personnel decisions, managed care plans, defense of legal matters, business planning, and outside storage of records.

Appointment Reminders: We may call to remind you of scheduled appointments, or notify you of other treatments or services available at our office that might help you.

Use and Disclosure without an Authorization: In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Situations might include a state or federal law that mandates certain health information be reported for a specific purpose, public health concerns, disclosures to governmental authorities about victims of suspected abuse, for health oversight activities, for judicial and administrative proceedings, law enforcement purposes, disclosure to a medical examiner, for health related research, to prevent a serious threat to health or safety, for specialized government functions, for lawful national intelligence activities, for military purposes, or for the evaluation and health of members of the foreign service, workers compensation programs, disclosures to business associates who perform healthcare operations for us and who agree to keep your health information private.

Other Disclosures: we will not make any other disclosures to your health information unless you sign a written authorization form. You do not have to sign such a form. If you do sign one, you make revoke it at any time unless we have already acted in reliance upon it.

Your Rights Regarding Your Health Information: The law gives you many rights regarding your health information. You can ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or healthcare operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for restriction send a written request to our office at the address shown at the beginning of this notice. You can ask us to communicate with you in a confidential way, such as phoning you at work rather than at home, by mailing health information to a different address. We will accommodate these requests if they are reasonable, and if you pay us for the extra costs. If you want to ask for confidential communications, send a written request to **Dr. Gallagher or Dr. Martin.** You can ask to see or get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access of copying. You will be able to review or have a copy of your health information within 30 days of asking us, or 60 days if the information is stored off-site. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally required. By law, we can have one 30 day extension of the time for us to give you access or photocopies of your health information, send a written request to our office. You can ask us to amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position and we will include it with your health information, send a written request, including your reasons for the amendment, to **Dr. Gallagher or Dr. Martin.** You can get a list of the disclosures that we have made of your health information within the past six years (or shorter period if you want) effective July 20, 2011. By law, the list will not include disclosures for purposes of treatment, payment, or healthcare operations, disclosures made in accordance with an authorization signed by you, and some other limited will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to our office.

Our Notice of Privacy Practices: By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice anytime. If we change this notice, the new privacy practices will apply to your health information that we already have, as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office and have copies available.

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, or Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to **Dr. Gallagher or Dr. Martin.**

For More Information: If you want more information about our privacy practices, call or visit our office at the address or phone number shown at the beginning of this notice.

Please direct any inquiries/complaints to Shannon Lambach 530-222-3166. She will be reached during normal business hours.

Enterprise Optometry Group, Inc.

Dr. Mitch Martin Dr. Gary Gallagher Dr. Diana Iraheta

No-show Policy Form

This practice reserves the right to charge a $50 no show fee to patients who fail to keep their appointments, or do not cancel their appointments, without notifying the practice.

We ask that all patients please give us 24 hours notice of cancellation. To ensure we do the best job possible keeping you informed about your appointments in a timely manner, we request that you frequently check your contact information we have in our files.

I, (please print) _____, have read and understand the No Show Policy and do agree that if I do not cancel my appointment 24 hours prior to my appointment, or if I do not attend my appointment, I will be charged the $50 fee.

Patient signature: _____

Date:_____

3080 Victor Ave, Redding, CA 96002 530-222-3166