Welcome to Our Office!

Patient Last Name_____, **First** _____ **MI** _____

DOB ___/___/_____ **Age**____ **Sex M F Marital Status M S W SSN #**_____

Address_____ **City** _____

State_____ **ZIP** _____ **Occupation/Employer**_____

E-mail_____

Phone: Home (____**)** _____ **Work (**____**)** _____ **Cell (**____**)** _____

Vision Insurance Carrier _____ **Member #**_____

Medical/Health Insurance Carrier_____ **Member Name**_____
DOB of Member ___/___/____ **Relationship to Member: Self Spouse Child**

Who do we have to thank for ***referring*** you to our office? _____
Did you see any advertisement for Westbrook Vision Center? _____

Last **Eye Exam** _____ Where/Doctor_____ Last **Physical Exam** _____

[ ] No [ ] Yes Are you interested in ***Contact Lenses*****?**
[ ] No [ ] Yes Have you worn Contact Lenses? If so, what type? (Please circle all that apply)
Soft Disposable Daily Wear Extended Wear Toric Multi/bifocal Hard/gas perm
[ ] No [ ] Yes Are you interested in ***Refractive Surgery*** **(LASIK)**?
[ ] No [ ] Yes Have you had ***eye surgery*****?** Cataract, LASIK, RK, Eye Muscle, Other_____
If so, when? _____

Present History

Please check the symptoms you are experiencing:
[ ] Blurred vision at Distance [ ] Eye Discomfort/Irritation [ ] Redness [ ] Dryness [ ] Itching
[ ] Blurred Vision at near [ ] Tired Eyes [ ] Eye Pain [ ] Sore eyes [ ] Double Vision
[ ] Headaches [ ] Other Concerns_____
[ ] No [ ] Yes Do you suffer from ***seasonal allergies***? Do they affect your eyes? _____
[ ] No [ ] Yes Do you use a ***computer***? Approximate # of hours per day? _____
[ ] No [ ] Yes Have you been diagnosed with ***eye problems***?
[ ] Cataract [ ] Glaucoma [ ] Macular Degeneration [ ] Dry Eye
Other/explain _____
[ ] No [ ] Yes Are you ***taking any medications***? (Include vitamins):_____
_____
[ ] No [ ] Yes Do you have any ***allergies to medications***? (List)_____

Family History

[ ] No [ ] Yes has anyone ***in your family*** been diagnosed with any of the following conditions listed below?
[ ] Blind [ ] Cataract [ ] Glaucoma [ ] Macular Degeneration [ ] Retinal Problems
[ ] Diabetes [ ] Hypertension
[ ] Other/Explain_____
Is there anyone else in your family in need of our services? _____
_____

Please Turn Page Over **– Additional Question are on Reverse Side**

Social History **(All information on this form is strictly confidential)**

[ ] No [ ] Yes Do you use tobacco products? What type and how many years? _____
[ ] No [ ] Yes Do you drink alcohol?
[ ] No [ ] Yes Do you use any illegal drugs? _____
[ ] No [ ] Yes Have you been diagnosed with [ ] HIV/AIDS [ ] Gonorrhea [ ] TB [ ] Hepatitis [ ] Chlamydia [ ] Herpes [ ] Syphilis

Review of Systems: Please indicate your response with a check mark below.

Constitutional [ ] None
[ ] Developmental disability
[ ] Weight Gain / Weight Loss
[ ] Fever
[ ] Fatigue

Ear, Nose, & Throat [ ] None
[ ] **Allergies** / Hay fever
[ ] Ear Infection
[ ] Sinus congestion

Cardiovascular [ ] None
[ ] Heart Attack
[ ] Hypertension/**High blood press**
[ ] Congestive Heart Failure
[ ] Arrhythmia
[ ] High Cholesterol
[ ] Aneurysm
[ ] Pacemaker

Respiratory [ ] None
[ ] **Asthma**
[ ] Bronchitis
[ ] Emphysema
[ ] COPD
[ ] Lung Cancer

Gastrointestinal [ ] None
[ ] Crohn's Disease
[ ] Colitis
[ ] Ulcer
[ ] Digestive Problems

Genitourinary [ ] None
[ ] Urinary tract infection (UTI)
[ ] Kidney infection / disease
[ ] STD/Herpes/Chlamydia
[ ] Ovarian/prostate cancer

Musculoskeletal [ ] None
[ ] Fibromyalgia
[ ] Muscular Dystrophy
[ ] Arthritis
[ ] Ankylosing Spondylitis
[ ] Lupus

Integumentary/Skin [ ] None
[ ] Eczema
[ ] Rosacea acne
[ ] Psoriasis
[ ] Skin Cancer

Neurological [ ] None
[ ] Multiple Sclerosis
[ ] Alzheimer's
[ ] Seizures
[ ] Stroke/CVA
[ ] Parkinson's

Psychiatric [ ] None
[ ] Depression
[ ] Panic Disorder
[ ] Schizophrenia
[ ] Drug Dependence

Endocrine [ ] None
[ ] **Diabetes**
[ ] Thyroid Dysfunction
[ ] Pituitary Dysfunction
[ ] Hormonal Dysfunction

Liver / Lymph System [ ] None
[ ] Anemia
[ ] Leukemia
[ ] Bleeding Disorder

Allergic / Immunologic [ ] None
[ ] Drug allergies
[ ] Environmental allergy
[ ] Rheumatoid arthritis
[ ] Lupus
[ ] AIDS
[ ] HIV

Women
[ ] Breast Cancer
[ ] Hysterectomy

If you answered **YES** to any of the above or have any condition not listed, please explain: _____

_____

Method of Payment: [ ] Cash [ ] Check [ ] Visa [ ] MC [ ] Am Express

I, the patient, authorize any holder of medical/optical information to release information about me to other health care professionals, attorneys, or insurance companies via mail or electronic transmission. I authorize and request that payments made under my insurance plan be made directly to Westbrook Vision Center PLC for services furnished to me. Contact lens prescriptions are not released until after the initial fitting and follow-up care is complete. **Waiver of Liability** – Medicare will only pay for services considered to be "reasonable & necessary". Medicare may deny payment for services (exam for glasses/contacts, visual field screening, contact lenses, photos, etc.). Therefore, you, "the patient" is personally fully responsible for payment in the event your insurance denies reimbursement.

I have read and understand the above information.

→ Signature _____ Date _____/_____/20_____

Receipt of Notice of Privacy Policies and Consent Form

Westbrook Vision Center PLC.
8877 W Union Hills Dr Ste D460 Peoria AZ 85382

This form must be signed by the patient or guardian of the patient for our office to provide services to the patient.
Federal Law requires us to use this form and accept and enforce these policies.
This form is mandated by the Health Insurance Portability and Accountability Act (HIPAA) Federal Law [45 CFR § 164.506]

Summary: HIPAA DOCUMENT MEANING & Purpose: The purpose of this document is to protect patient rights to privacy. This document states the office of Drs. Deemer, Smith & Associates, P.C. is compliant with the HIPAA rules & regulations and we are to protect your health care information.

You "the patient" **may refuse to sign this document**. Refusal to sign does not give our office permission to submit vision care claims on your behalf or obtain authorization or proof of insurance of your behalf, therefore, you **"the patient", will be required to pay in full at time of service with CASH** (No discounts or insurance plans will be accepted).

→ Patient Name: _____ _____
Print First Name Last Name

This document is now required when you see Healthcare Professionals. In the course of providing services to you, 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 to conduct health care operations involving our office.

The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of you health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated 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 your services and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices*.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy a Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Drs. Deemer, Smith, and Associates, P.C.

→ **Signature**_____ **Date**_____

If you are under 18 years of age, a guardian, or parent must sign below
Signature _____ Print Name_____
Source of Authority [ ] Guardian [ ] Parent [ ] Other_____ Date____/____/20___

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