

*Thank You For Choosing*  
**All Eye Care Optometry**  
 New Patient  Returning Patient

Name \_\_\_\_\_ Sex \_\_\_\_\_ Date \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone \_\_\_\_\_ Cell \_\_\_\_\_ E-mail \_\_\_\_\_

Birth day \_\_\_\_\_ Age \_\_\_\_\_ Social Security \_\_\_\_\_

Employer \_\_\_\_\_ How Long? \_\_\_\_\_ Occupation \_\_\_\_\_

Business Phone \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_

**Children**

Names and Ages \_\_\_\_\_

**Spouse**

Name \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Business Phone \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_

**Students**

School \_\_\_\_\_ Year/Grade \_\_\_\_\_

Father \_\_\_\_\_ Mother \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Occupation \_\_\_\_\_ Phone \_\_\_\_\_ Occupation \_\_\_\_\_ Phone \_\_\_\_\_

Work Address \_\_\_\_\_ Work Address \_\_\_\_\_

Family members in our practice \_\_\_\_\_

Patient Accompanied by \_\_\_\_\_ Contact # \_\_\_\_\_

**Insurance**

Primary Insured=s Name \_\_\_\_\_ Birthday \_\_\_\_\_ ID/SS# \_\_\_\_\_

Vision /Optical \_\_\_\_\_ Medical \_\_\_\_\_

Referred by \_\_\_\_\_

**Please read Insurance regulations before signing:**

1. Insurance identification and authorization is required **prior** to services provided or applied.
2. Authorization for release of medical or personal information necessary to process insurance claim is hereby given.
3. Payment for non-covered items are patient=s responsibility.
4. Delay or quality of eye wear from insurance lab is responsibility of insurance company regardless of overages paid.
5. This agreement holds All Eye Care Optometry harmless for any disputes arising from insurance orders.

**Patient or Responsible Party ' s Signature** \_\_\_\_\_

# YOUR LIFESTYLE QUESTIONNAIRE

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Everyday activities, diversions, special interests require good vision. We use our eyes for most everything. How they work for us is directly related to whether we feel comfortable doing what we do. Of course computers are a big part of our lives and most of us notice something about our eyes when we use them. But there are so many other activities we do that are important to us where vision function is foremost.

**To better design a vision plan please check and describe the following, which applies to you:  
Please use the other side of this page for additional remarks.**

- |  |                            |                        |
|--|----------------------------|------------------------|
| <input type="checkbox"/> Go to Movies    | Seating? Front/Middle/Back | How often? _____       |
| <input type="checkbox"/> Sports          | Type _____                 | How often? _____       |
| <input type="checkbox"/> Play Instrument | Type _____                 | How often? _____       |
| <input type="checkbox"/> Crafts          | Type _____                 | How often? _____       |
| <input type="checkbox"/> Hobbies         | Type _____                 | How often? _____       |
| <input type="checkbox"/> Leisure         | Type _____                 | How often? _____       |
| <input type="checkbox"/> Dance           | Type _____                 | How often? _____       |
| <input type="checkbox"/> Sing            | Type _____                 | How often? _____       |
| <input type="checkbox"/> Sew             | Hand or Machine            | How often? _____       |
| <input type="checkbox"/> Paint/Draw      | Type _____                 | How often? _____       |
| <input type="checkbox"/> Sculpt          | Type _____                 | How often? _____       |
| <input type="checkbox"/> School          | Course _____               | How often? _____       |
| <input type="checkbox"/> Drive           | Vehicle _____              | Average Mileage? _____ |
| <input type="checkbox"/> Shop            | Where _____                | How often? _____       |
| <input type="checkbox"/> Lecture/Speak   | Where _____                | How often? _____       |
| <input type="checkbox"/> Act             | Where _____                | How often? _____       |

*This information is vital for designing the most effective means to make your life more enjoyable and productive. Dr. Goldstein and the All Eye Care Team thank you for allowing us to provide you with the best eye care available.*

# All Eye Care Optometry

## Medical History Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

### **Social History:**

- Nutritional Supplements       Vitamins       Regular Exercise      How often: \_\_\_\_\_
- Drink Alcohol      How often: \_\_\_\_\_
- Smoke Tobacco      How often: \_\_\_\_\_
- Chew Tobacco      How often: \_\_\_\_\_

Hobbies and/or Interests: \_\_\_\_\_

### **Spectacle Lens History:**

- Computer      Hours per day? \_\_\_\_\_ Distance from computer? **Close/ Arm Length/ 3ft. or More**
- Drive      Mileage per day? \_\_\_\_\_ Visual difficulty when driving? When? **Night/ Glare/ Fog/ All the time**

**Glasses worn for:**       Full Time       Safety wear       Computer       Reading       Sports

**Type of Lenses**       Single Vision (Distance./Near)       Bifocals       Progressives (No line bifocals)       Trifocal

**Sunglasses Info:**       Regular       Prescription       Polarized       UV Protection       Transitions

### **Any Extra Pairs of Glasses for:**

- Computer (special anti-reflection tints or enhancements)       Sports/ Hobbies Glass wear
- Occupational (mechanics, plumbers, pilots)       Safety Glasses (gardening, woodworking, welding)

### **Contact Lens History:**

Current Contact Wearer      Since \_\_\_\_\_ How many hrs/day? \_\_\_\_\_ How many days/weeks? \_\_\_\_\_

Do you ever sleep in your contacts? \_\_\_\_\_ Could change one thing it would be? \_\_\_\_\_

If your not a contact wearer, are you interested in trying contacts? \_\_\_\_\_

Have you ever tried contacts? \_\_\_\_\_ Reason for stopping? \_\_\_\_\_

Brand of Contacts and Prescription \_\_\_\_\_

### **Please rate the following on a scale of 1-10 with 1 being POOR and 10 being EXCELLENT**

Lens Comfort: Right\_\_\_\_ Left\_\_\_\_      Distance Vision: Right\_\_\_\_ Left\_\_\_\_      Near Vision: Right\_\_\_\_ Left\_\_\_\_

What Solutions do you use? Cleaner \_\_\_\_\_ Disinfectant \_\_\_\_\_ Enzyme \_\_\_\_\_

### **Any Information for the Doctor regarding your Glasses, Contacts or Vision in General:**

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# All Eye Care Optometry

## PATIENT HISTORY AND INFORMATION

FIRST NAME

LAST NAME

DATE

PRIMARY CARE PHYSICIAN AND/OR CLINIC NAME

ADDRESS

CITY

STATE/ZIP

PHONE

REFERRING PHYSICIAN NAME

ADDRESS

CITY

PHONE

### HEALTH HISTORY:

Reason for Today's Exam? \_\_\_\_\_ Last Eye Exam? \_\_\_\_\_ Last Health Exam? \_\_\_\_\_

Past Surgeries, Illnesses or Injuries: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Current Eye Drops: \_\_\_\_\_

Medicines that cause allergies, reactions or sensitivities: \_\_\_\_\_

#### Your Eye History

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Cataract       | <input type="checkbox"/> Macular Degeneration    | <input type="checkbox"/> Color Blindness       |
| <input type="checkbox"/> Headaches        | <input type="checkbox"/> Tired Eyes     | <input type="checkbox"/> Glare/Light Sensitive   | <input type="checkbox"/> Amblyopic (lazy eye)  |
| <input type="checkbox"/> Burning          | <input type="checkbox"/> Dryness        | <input type="checkbox"/> Excess Tearing/Watering | <input type="checkbox"/> Foreign Body          |
| <input type="checkbox"/> Itching          | <input type="checkbox"/> Redness        | <input type="checkbox"/> Pain or Soreness        | <input type="checkbox"/> Infection             |
| <input type="checkbox"/> Drooping Eyelid  | <input type="checkbox"/> Double Vision  | <input type="checkbox"/> Mucus Discharge         | <input type="checkbox"/> Sandy/Gritty Feeling  |
| <input type="checkbox"/> Blurred Distance | <input type="checkbox"/> Blurred Near   | <input type="checkbox"/> Strabismus (turned eye) | <input type="checkbox"/> Distorted Vision Halo |
| <input type="checkbox"/> Floaters/Spots   | <input type="checkbox"/> Loss of Vision | <input type="checkbox"/> Fluctuating Vision      | <input type="checkbox"/> Loss of Side Vision   |

#### Your General Health History

- |                                   |   |   |   |
|-----------------------------------|---|---|---|
| <input type="checkbox"/> Fever    | <input type="checkbox"/> Weight Loss      | <input type="checkbox"/> Blood/Lymph            | <input type="checkbox"/> Ears, Nose, Throat |
| <input type="checkbox"/> Kidney   | <input type="checkbox"/> Cardiovascular   | <input type="checkbox"/> Respiratory (Asthma)   | <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> Skin     | <input type="checkbox"/> Neurological     | <input type="checkbox"/> Thyroid, Diabetes      | <input type="checkbox"/> Other Symptoms     |
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Muscles, Bones, Joints |   |

#### Family History

- |                                    |                                      |   |  |
|------------------------------------|--------------------------------------|---|--|
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Cataract(s) | <input type="checkbox"/> Amblyopia (Lazy Eye) | <input type="checkbox"/> Color Blindness       |
| <input type="checkbox"/> Glaucoma  | <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Retinal Detachment   | <input type="checkbox"/> Strabismus (eye turn) |
| <input type="checkbox"/> Cancer    | <input type="checkbox"/> Diabetes    | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Kidney Disease        |
| <input type="checkbox"/> Lupus     | <input type="checkbox"/> Stroke      | <input type="checkbox"/> Thyroid Disease      | <input type="checkbox"/> Macular Degeneration  |

# NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used or disclosed and how you can get access to this information. Please review 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 must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and applicable law permits the terms of this Notice at any time, provided such changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

## USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations.

**For examples: Treatment,** we maybe use or disclose your health information to a physician or other healthcare provider providing treatment for you.

**Payment,** we may disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to se your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was sin effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

**To your family and friends:** We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons involved in care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, or your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our 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, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

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

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You may refuse to sign this acknowledgement\***

I, \_\_\_\_\_, have read and understand the Notice of Privacy Practices.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## OFFICE ONLY:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify on back)