Medical History Questionnaire

Date: _____ M or F: _____

Patient's Name: _____ Date of Birth: _____

Address _____

City_____ State _____ Zip Code _____

Email Address _____ Social Security _____

Cell Phone _____ Work Phone_____

Employer _____ Occupation _____

Name of Medical Doctor _____ Phone Number _____

Personal Medical Information: Do you have problems with any of these systems?

____ Gastrointestinal	____ Nervous System	____ Mental
____ Ear/Nose/Throat	____ Genitourinary	____ Endocrine (Glands)
____Cardiovascular	____ Musculoskeletal	____ Blood/Lymph
____ Respiratory	____ Skin	____ Allergic/Immunologic
____ Headaches		

List any Surgeries (what type and when):

_____

Medication List

_____

Allergies to Medication? If yes, please list them below. ____ Yes ____ No

_____

Do you smoke?	____ Yes	____ No
Do you drink alcohol?	____ Yes	____ No
Do you use any other substances?	____ Yes	____ No

Do you have family history of any of the following?

____ Diabetes	____ Glaucoma	____ High Blood Pressure
____ Macular Degeneration	____ Retinal Detachment	____ Cataracts

Note: Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. **I understand that I am responsible for any balance my insurance does not pay.**

Signature _____ Date_____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- You have the right to a paper copy of this notice of privacy practices.

May we discuss your condition with any family member? If so, please list their names below:

_____

Signature _____ Date _____