

## Welcome to our office

Mr. Mrs. Ms. Miss Dr. Fr.  Single  Married  Other \_\_\_\_\_ Date \_\_\_\_\_

Last \_\_\_\_\_ First \_\_\_\_\_ Mi \_\_\_\_\_

Address \_\_\_\_\_ Apt \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ Drivers License# \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ ext \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_ Social Security \_\_\_\_\_

E-Mail \_\_\_\_\_ Occupation \_\_\_\_\_

Date of last Eye Exam (estimate) \_\_\_\_\_ Dilated  Y  N

Reason for Visit Today (Please circle the box that applies to you)

Blurred Distance Vision	<input type="checkbox"/> Y	<input type="checkbox"/> N	Itch burn or Tear	<input type="checkbox"/> Y	<input type="checkbox"/> N	Dry Eyes	<input type="checkbox"/> Y	<input type="checkbox"/> N
Blurred Near Vision	<input type="checkbox"/> Y	<input type="checkbox"/> N	Double Vision	<input type="checkbox"/> Y	<input type="checkbox"/> N	Broken Glasses	<input type="checkbox"/> Y	<input type="checkbox"/> N
General Blurred Vision	<input type="checkbox"/> Y	<input type="checkbox"/> N	Amblyopia	<input type="checkbox"/> Y	<input type="checkbox"/> N	Flashes of Light	<input type="checkbox"/> Y	<input type="checkbox"/> N
Want Contact Lenses	<input type="checkbox"/> Y	<input type="checkbox"/> N	Cataracts evaluation	<input type="checkbox"/> Y	<input type="checkbox"/> N	Eye Injury Today	<input type="checkbox"/> Y	<input type="checkbox"/> N

Health History (Do you have problems with any of these systems?)

Good General Health	<input type="checkbox"/> Y	<input type="checkbox"/> N	Stomach	<input type="checkbox"/> Y	<input type="checkbox"/> N	Migraines	<input type="checkbox"/> Y	<input type="checkbox"/> N
Ear/Nose/Throat	<input type="checkbox"/> Y	<input type="checkbox"/> N	Urinary	<input type="checkbox"/> Y	<input type="checkbox"/> N	Mental	<input type="checkbox"/> Y	<input type="checkbox"/> N
Cardiovascular	<input type="checkbox"/> Y	<input type="checkbox"/> N	Bone/ Arthritis	<input type="checkbox"/> Y	<input type="checkbox"/> N	Metabolism	<input type="checkbox"/> Y	<input type="checkbox"/> N
Hypertension	<input type="checkbox"/> Y	<input type="checkbox"/> N	Infective Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Diabetic	<input type="checkbox"/> Y	<input type="checkbox"/> N
Cholesterol	<input type="checkbox"/> Y	<input type="checkbox"/> N	Skin	<input type="checkbox"/> Y	<input type="checkbox"/> N	Thyroid	<input type="checkbox"/> Y	<input type="checkbox"/> N
Respiratory	<input type="checkbox"/> Y	<input type="checkbox"/> N	Neurological	<input type="checkbox"/> Y	<input type="checkbox"/> N	Allergic condition	<input type="checkbox"/> Y	<input type="checkbox"/> N
Do you smoke	<input type="checkbox"/> Y	<input type="checkbox"/> N	Drink alcohol	<input type="checkbox"/> Y	<input type="checkbox"/> N	Illegal drug use	<input type="checkbox"/> Y	<input type="checkbox"/> N

Ocular and Family History (Please circle the box that applies to you or circle family if it runs in the family )

Glaucoma	<input type="checkbox"/> Y	<input type="checkbox"/> N	family	Retinal disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	family	Amblyopia	<input type="checkbox"/> Y	<input type="checkbox"/> N	family
Cataracts	<input type="checkbox"/> Y	<input type="checkbox"/> N	family	Other Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	family	Dry Eye	<input type="checkbox"/> Y	<input type="checkbox"/> N	family
Cataract Surgery	<input type="checkbox"/> Y	<input type="checkbox"/> N	family	Blindness	<input type="checkbox"/> Y	<input type="checkbox"/> N	family	Eye Injury	<input type="checkbox"/> Y	<input type="checkbox"/> N	family
Macular Degeneration	<input type="checkbox"/> Y	<input type="checkbox"/> N	family	Strabismus	<input type="checkbox"/> Y	<input type="checkbox"/> N	family	Eye Surgery	<input type="checkbox"/> Y	<input type="checkbox"/> N	family

List medication taken now

How often

For what condition

1.		
2.		
3.		
4.		
5.		
6.		

Y  N Allergic to Medication if Y list \_\_\_\_\_

Y  N Do you wear Contact Lenses if Yes Brand/Type/Powers \_\_\_\_\_

Y  N **Dilation Today**(read back of form)  **Reschedule for a Office visit with Fee**  **Discuss with Doctor**

Y  N **\$15 Retinal Photo screening** ( read back of form ) **done today for \$15 on top of your exam fee .**  **Discuss with Doctor**

**Dilations may not be required and are preformed less often if you have your regular Photo of the eye.**

### ADDITIONAL TEST FEES

### POLICIES

- \* **There are additional fees for Contact Lens Evaluation.** Please inquire
- \* **We make no guarantees about YOUR insurance in coverage or payment. Any shortfall in payment is your Responsibility and you agree to pay us promptly when notified.** Please inquire
- \* I have read (on back of this form ) the informed consent about dilated eye exam .
- \* I have read ( on back of this form ) and agree to the patient privacy act
- \* I have read ( on back of this form ) and agree to the retinal photo

### Please sign

**PLEASE PROVIDE THE STAFF WITH YOUR MEDICAL INSURANCE CARD AND VISION INSURANCE INFO**

## EYESCREEN PHOTOGRAPHIC EXAMINATION

EyeScreen is a high resolution screening photograph of the back of your eye, the retina, which will help us document, review, and compare your retina over time. That is why we have the photo on every patient every year as our standard of care. We will use the EyeScreen exam to document baseline image for our electronic charts, screen for eye diseases and improve our ability to view your internal retinal health much easier and clearer than the light into the eye with the Ophthalmoscope. Insurance is designed to pay for photographs only if existing eye disease is present. If you have not been diagnosed with and eye disease, insurance will not cover the EyeScreen Examination. Our Doctor believes that should be included on every patient every year. The fee is \$15. ( State plans like caloptima excluded by law ). Having a Photo of the eye reduces the need and how often we need to do the Dilation of the eye. It's much easier for the patient.

Yes I agree to the \$15 Fee \_\_\_ No I decline \_\_\_ I would like to discuss this with the staff /Doctor \_\_\_

## INFORMATION REGARDING DILATING EYE DROPS

**DILATING DROPS** are used to dilate or enlarge the pupils of the eye to allow the Eye Doctor to completely evaluate the health of your eyes. Without dilation the Doctor can not get a full view of your eye to do a complete health evaluation. For Dilation your pupils will become unusually large and you will have blurring of vision for around 2 to 4 hours , especially for things that are close to you. Sunglasses will be provided for you because you will be sensitive to light. Driving may be difficult after an dilation, if that happens to you it's best if wait for the effects to wear off or you make arrangements not to drive yourself. Do not operate machinery. If you have difficulty with walking, balance or blurred vision, you will need to use caution when walking to prevent falls. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. **IF YOU HAVE PAIN IN YOUR EYES A FEW HOURS AFTER DILATION SEEK CARE AT THE ER, URGENT CARE, OR THROUGH YOUR INSURANCE AGREEMENTS. CALL OUR OFFICE FOR ADVICE.** Please report to the Doctor if you have been dilated before and had some adverse side effects. Dilation needs to be done periodically, every year to every 5 years, to fully evaluate the retinal health of the eye and especially 1) All diabetics every year 2) High nearsighted patients 3) Hypertension patients 4) First time patients

**Yes \_\_\_ No I decline \_\_\_ Discuss with Doctor \_\_\_ I would like to appoint for a different day for an office visit fee \_\_\_**

## NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE IS EFFECTIVE 12/12/02 UNTIL FURTHER NOTICE. **Right to Notice** As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPAA). Dr. Chiana's Eyecare Center can use your protected health information for treatment, payment and health care operations. a) Treatment - We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. b) Payment - We may use and disclose your health information to obtain payment for services we provide you. c) Health care 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 competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. **Your Authorization** Most uses and disclosures that do not fall under treatment, payment, health care operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time. **Emergency Situations** In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare. **Marketing** We will not use your health information for marketing communications without your written authorization. **Required by Law** We may also use or disclose your health information when we are required to do so by law. **Abuse or Neglect** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety. **National Security** We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances. **Appointment Reminders** We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter. **Your Rights as a Patient** You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or health care operations. -You have the right to receive confidential communications regarding your protected health information. -You have the right to inspect and copy your protected health information. -You have the right to amend your protected health information. -You have the right to receive an account of disclosures of your protected health information. -You have the right to a paper copy of this notice of privacy practices. **Legal Requirements** Dr. Chiana's Eyecare Center is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted or are available within our office. **Complaints** If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint. **Contact Information** For further information about Dr. Steven J Chiana's Eyecare Center's privacy policies, please contact Dr. Steven J. Chiana Eyecare Center 1839 w Orangethorpe ave, Fullerton Ca 92833 (714) 879-2020 Dr. Steven Chiana or supervisor I understand that the above refers to my rights under the Health Insurance Portability and Accessibility Act (HIPAA). I may ask for a copy of this.

**Patient Initials** \_\_\_\_\_