Advanced Family Eyecare

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14000 Quailbrook Dr., Oklahoma City, OK 73134
(405) 751-7727 Fax (405) 755-1875

Please print in blue or black ink. Chart # ______________________

Patient Name: _______________________________ **Preferred Name:** _____________________ **Age:** ________ **Date:** _________
Address: ______________________________ City: _____________________________ State: __________ Zip: __________________
Home Phone: ___________________________ Cell Phone: _______________________________ Business Phone: ________________
Email address: ______________________________ Date of Birth: ______________________ Gender: ❑ M ❑ F SSN: ____________
Employer: ____ Position: ___________________________________
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Legally Separated ❑ Widowed
Spouse's Name:____ Phone Number: _______________________
Employer: ____ Position: ___________________________________
Race: ❑ White ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic ❑ Native Hawaiian/ other Pacific Island
Ethnicity: ❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑ Native Hawaiian/other Pacific Island
Preferred Language: ❑ English ❑ Spanish
Who may we thank for referring you to our practice? ____
May we use your name in thanking them? ❑ Yes ❑ No
Reason for today's visit: ____
Do you have any specific questions for your doctor today? ____
Are you planning on new eyeglasses today? ❑ Yes ❑ No ❑ Maybe Are you planning on purchasing contacts? ❑ Yes ❑ No
If not a contact lens wearer, are you interested in trying contacts today? ❑ Yes ❑ No ❑ Maybe
Are you interested in learning more about laser vision correction? ❑ Yes ❑ No

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Contact Lens History:

Do you currently wear contact lenses? ❑ Yes ❑ No Hours per day: __________ Days per week: ________
Brand you are currently wearing? ____________________________ Today's wearing time? ________ Age of current lenses? _____
What contact solution are you currently using? ____
If not wearing contacts now, have you tried them in the past? ❑ Yes ❑ No Reason for discontinued wear? __________

Glasses History:

Do you currently wear glasses? ❑ Yes ❑ No - If yes please select: ❑ Full-time ❑ Part-time Distance ❑ Part-time Near
Glasses currently worn: ❑ Single Vision ❑ Bifocals ❑ Progressive ❑ Trifocals
How old were you when glasses were first prescribed? ______________
Do you wear sunglasses? ❑ Yes ❑ No Are your sunglasses your most recent prescription? ❑ Yes ❑ No
Do you have any hobbies or jobs that require special glasses or contacts? ____

Other Visual History:

From whom did you receive your last eye examination ______________________________ Date of last exam: ________________
Why did you leave their practice? ____
Have you had any: Head Injuries? ❑ Yes ❑ No Head/Eye surgeries? ❑ Yes ❑ No
Illnesses involving eyes or head: ❑ Yes ❑No
Do you have headaches? ❑ Yes ❑ No How often? ______________________ Location? ____________________________________
What relieves the headache? ______________________________________
Which describes your headache? (check all that apply) ❑ Dull ❑ Throbbing ❑ Aching ❑ Constant ❑ Sharp ❑ Other _______

Social History:

Use of Alcohol: ❑ None ❑ Social use only ❑ 1-2 drinks daily ❑ Above average use ❑ Alcohol dependence
Use of Tobacco: ❑ None ❑ Former Smoker ❑ Light Smoker ❑ Average Smoker ❑ Heavy Smoker
Use of Narcotic: ❑ None or Type & frequency: ____________________
Sexually Transmitted Disease: ❑ Yes ❑ No If yes, name kind of STD ____________ HIV Positive? ❑ Yes ❑ No

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Family Members (please list):

Name/Relationship to you	Age	Last Eye Exam	Name/Relationship to you	Age	Last Eye Exam

Current Medications (please list):

1. ____________ for ____________ 6. ____________ for ____________
2. ____________ for ____________ 7. ____________ for ____________
3. ____________ for ____________ 8. ____________ for ____________
4. ____________ for ____________ 9. ____________ for ____________
5. ____________ for ____________ 10. ____________ for ____________

Drug Allergies ❑ Yes ❑ No Please list: ____________________

Ocular History

Please list all ocular surgeries:
Procedure: ____________________ Year: ________ Eye: R / L Doctor: ________
Procedure: ____________________ Year: ________ Eye: R / L Doctor: ________
Procedure: ____________________ Year: ________ Eye: R / L Doctor: ________

Current Eye Symptoms/Conditions: (check all that apply)

❑ Headaches
❑ Glare/Light Sensitivity
❑ Tired Eyes
❑ Amblyopia/Lazy Eye
❑ Burning
❑ Dryness
❑ Itching
❑ Redness
❑ Excess Tearing/Watering
❑ Eye Pain/Soreness
❑ Sandy/Gritty Feeling
❑ Double Vision
❑ Mucous Discharge
❑ Distorted Vision/Halos
❑ Floaters
❑ Flashes of light
❑ Blurred Distance Vision
❑ Blurred Near Vision
❑ Fluctuating Vision
❑ Glaucoma
❑ Cataracts
❑ Retinal Detachment
❑ Macular Degeneration
❑ Skipping lines when reading
❑ Problems Driving at Night
❑ Poor reading comprehension
❑ Head Tilt
❑ Fluorescent light sensitivity
❑ Others (Please list):
____
____
____

Medical History

Indicate any personal history below: (check all that apply)

Cardiovascular:
❑ Congestive Heart Failure
❑ Elevated Cholesterol
❑ High Blood Pressure
❑ Stroke

Endocrine:
❑ Diabetes
❑ Gout
❑ Thyroid (High or Low)
❑ Renal Disease (Kidney)

Gastrointestinal:
❑ Cancer: Colon, Liver
❑ Colitis
❑ Hepatitis
❑ Inflammatory Bowel Disease

Integumentary:
❑ Acne Rosacea
❑ Lupus
❑ Psoriasis
❑ Dizziness

Hematologic/Lymphatic:
❑ Leukemia
❑ Sickle Cell Disease
❑ Temporal Arteritis
❑ Lymphatic Disorder

Immunologic:
❑ AIDS
❑ Sarcoidosis
❑ Sjogren's Syndrome
❑ Syphilis

Musculoskeletal:
❑ Arthritis
❑ Rheumatoid Arthritis

Neurological:
❑ Bell's Palsy
❑ Brain Tumor
❑ Multiple Sclerosis
❑ Parkinson's Disease
❑ Seizures
❑ Psychiatric

Alzheimer's:
❑ Bipolar Disorder
❑ Depression
❑ Learning Disability
❑ Schizophrenia

Genitourinary:
❑ Menopause
❑ Prostate Cancer
❑ Cervical Cancer
❑ Breast Cancer

Head/ENT/Dental:
❑ Chronic Cough
❑ Migraines
❑ Sinusitis
❑ Dizziness

Respiratory:
❑ Asthma
❑ COPD
❑ Emphysema
❑ Lung Disorder

❑ GERD (Acid Reflux) ❑ Tuberculosis ❑ Anxiety Disorder ❑ Lung Cancer

Family Physician:

Name: ________________________ Phone: ______________ Date of Last Physical Exam: ________________

Family History:

Condition	*Relationship to Patient*	*Condition*	*Relationship to patient*
❑ Amblyopia/Lazy Eye	________________	❑ Cancer	________________
❑ Blindness	________________	❑ Diabetes	________________
❑ Cataracts	________________	❑ Heart Disease	________________
❑ Glaucoma	________________	❑ Stroke	________________
❑ Retinal Detachment	________________	❑ Thyroid Disease	________________
❑ Macular Degeneration	________________	❑ Other	________________

Other Information:

Would you like more information concerning the following?

❑ Contact Lenses	❑ Integrated Learning	❑ Occupational Lenses/Frames
❑ Visually Related Learning Disabilities	❑ Sports Lenses/Frames	❑ Lazy/Crossed Eyed Therapy
❑ Lens/Frame Advances	❑ Vision and Reading Problems	❑ Dry Eye Treatment
❑ Computer Vision Syndrome	❑ Laser Correction	❑ Infant Visual Care
❑ Sports Vision	❑ Lectures/Workshops	❑ Vision Therapy

Activities/Hobbies (check all that apply):

❑ Baseball	❑ Fishing	❑ Needlepoint	❑ Softball
❑ Basketball	❑ Gardening	❑ Painting	❑ Swimming
❑ Boating	❑ Golf	❑ Racquetball	❑ Television
❑ Card Playing	❑ Handball	❑ Reading	❑ Tennis
❑ Carpentry	❑ Hunting	❑ Repair (Home)	❑ Water Skiing
❑ Crafts	❑ Knitting	❑ Sewing	❑ Whittling
❑ Computers	❑ Model Making	❑ Shooting	❑ Woodworking
❑ Drawing	❑ Nature Study	❑ Snow Skiing	❑ Other

Has your vision been a problem for you in any sport or hobby? ______________________________

Thank you for completing the above questionnaire. A comprehensive history allows us to better meet your needs.

After completion, please fax form to (405) 755-1875 or email to info@afeyecare.com.

Payment Policy

1. Payment: Payment is expected at the time services are received.

2. Credit: Our office accepts Visa, MasterCard, American Express, Discover, and Care Credit

3. Insurance: We are not participating providers for any insurance companies. Therefore, payment is required to us at the time of service, and we will provide you the necessary paperwork for you to file your own insurance claim if you choose to do so. Your insurance company will reimburse you directly for the portion they are contracted to pay, *which may not be the full amount of the examination.*

Signature: ____________________________________ Date: ______________________

Performance Summary

Advanced Family Eyecare

14000 Quailbrook Dr.
OKC, OK 73134
(405) 751-7727
www.afeyecare.com

After you consider each question, mark the column that applies.	**Never**	**Seldom**	**Occasional**	**Frequent**	**Always**
Blur when looking at near	0	1	2	3	4
Double vision, doubled or overlapping words on page	0	1	2	3	4
Headaches while or after doing near vision work	0	1	2	3	4
Words appear to run together when reading	0	1	2	3	4
Burning, itching or watery eyes	0	1	2	3	4
Falls asleep when reading	0	1	2	3	4
Seeing and visual work is worse at the end of the day	0	1	2	3	4
Skips or repeats lines while reading	0	1	2	3	4
Dizziness or nausea when doing near work	0	1	2	3	4
Head tilts or one eye is closed or covered while reading	0	1	2	3	4
Difficulty copying from the chalkboard	0	1	2	3	4
Avoids doing near vision work such as reading	0	1	2	3	4
Omits (drops out) small words while reading	0	1	2	3	4
Writes up or down hill	0	1	2	3	4
Misaligns digits or columns of numbers	0	1	2	3	4
Reading comprehension low, or declines as day wears on	0	1	2	3	4
Poor, inconsistent performance in sports	0	1	2	3	4
Holds books too close, leans too close to computer screen	0	1	2	3	4
Trouble keeping attention centered on reading	0	1	2	3	4
Difficulty completing assignments on time	0	1	2	3	4
First response is "I can't" before trying	0	1	2	3	4
Avoids sports and games	0	1	2	3	4
Poor hand/eye coordination, such as poor handwriting	0	1	2	3	4
Does not judge distances accurately	0	1	2	3	4
Clumsy, accident prone, knocks things over	0	1	2	3	4
Does not use or plan his/her time well	0	1	2	3	4
Does not count or make change well	0	1	2	3	4
Loses belongings and things	0	1	2	3	4
Car or motion sickness	0	1	2	3	4
Forgetful, poor memory	0	1	2	3	4

Normal Score…..0-19
Suspect Problems….. 20-24
Examination Needed…..25 or Greater

NOTICE OF PRIVACY PRACTICES

Advanced Family Eyecare

Vision Source !
14000 Quailbrook Drive
Oklahoma City, OK 73134
Office (405) 751-7727
Fax (405) 755-1875
Web: www.afeyecare.com

THIS NOTICE DESCRIBED HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
(Revised 7-2013)

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care issues. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses; contact lenses; or eye medication and sending them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Example of how we use or disclose your health information for payment purposes are: asking you about you health or vision care plan, or other source of payment; preparing and sending bills or claims; and collecting unpaid balances (either ourselves or through a collection agency or attorney). "Health care operations' mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, (we will) (we usually will not) ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, that law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state of federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notice to and from the Federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims of suspected abuse, neglect, of domestic violence,
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audit by Medicare or Medicaid; for investigation of possible violations of health care laws;
- Disclosures for judicial and administrative proceeding, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- Uses or disclosures for health related research;

- Uses or disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized government functions such as for the protection of the President or high ranking government officials; for lawful national intelligence activities; for military purpose; or for the evaluation and health of members of the foreign service;
- Disclosure of de-identified information; unidentified
- Disclosure relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;
- Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/ or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DICLOSURES

We will not make any other uses or disclosures of you health information unless you sign a written "authorization form". The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person at the beginning of this notice.

We will not use or disclose any protected health information for marketing purposes or disclosures that constitute a sale of protected health information without your consent. Additionally, any other uses and disclosures not described in this notice will be made only with your authorization.

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 purpose of treatment (except emergency treatment), and payment or health care 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 a restriction, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E-mail to your personal E-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this notice.
- Ask to see or to get photocopies of your health information. By law, these are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty 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 available. By law, we can have a 30 day extension of time for us to give you access or photocopies of your health information. Send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this Notice.

- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree we will amend the information within 60 days of your request. We will send the corrected information to persons we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position that we will include with your health information along with any rebuttal statement. We will send this with your health information whenever a permitted disclosure is requested/ needed. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. IF you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax, or E-mail shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want).By law, the list will not include: disclosure for purposes of treatment payment or health care operations; disclosures for authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it. By law we can have a 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E- mail shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. Does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax, or E-mail shown at the beginning of the Notice.
- You may restrict certain disclosures of protected health information to a health plan when you pay out of pocket in full for the health care item or service.
- In the event that there is a breach of unsecured protected health information, you will be notified by our office within 30 days of the breach.

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 at any time as allowed by law. 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 may generate in the future. If we change our Notice of Privacy Practice, we will post the new notice in our office, have copies available in our office, and post it on our Website.

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, 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 the office contact person at the address, fax, or E-mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Advanced Family Eye Care Your *Vision Source!* Notice of Privacy Practices.

Patient Name: ____

Signature:____

Date: ____

Authorization for Release of Information

I hereby request the disclosure of information from my record.

Patient Name: ____
Address: ____
City/State/Zip:________________________/______/____________________
Phone: (________)____________________ DOB: _____/_____/______

The information is to be released **TO/FROM**:

Name/Agency: ____
Address: ____
City/State/Zip:________________________/______/____________________
Phone: (_________)____
Fax: (_________)____
E-mail: ____
Contact Person(s): ____

The information is to be released by mail, phone, email, or fax **TO/FROM**:

Advanced Family Eyecare
14000 Quailbrook Dr.
Oklahoma City, OK 73134
(405) 751-7727/ fax (405) 755-1875

The information to be released is as follows:

❑ Any information contained in the patient's record

❑ Only information related to the patient's educational success (Specify)

____
____
____

- I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date authorized.
- I understand that the recipient of the disclosed protected health information may not have any legal obligation to maintain the further confidentiality of the protected health information.
- We cannot refuse to treat you if you choose not to sign this form.

Signature: ______________________________________ Date: ___________________

(Patient, Parent, or Legal Guardian)