Piedmont Eye Associates

Patient Information

Name:			Social Security Number:	
Email Address:			Home Phone:	Cell Phone:
Mailing Address:				
City:	State:	Zip:	Date of Birth:	Sex: M / F

Required Information

Marital Status (Circle One): Single Married Divorced Widowed	**Race (Circle One):** Asian African-American Caucasian Hispanic Indian Other: Decline
Ethnicity (Circle One): Hispanic Non-Hispanic Decline	**Language (Circle One):** English Spanish French Russian Japanese Chinese Other:

Primary Policy Holder Information

Name:	Date of Birth:
Social Security Number:	Phone Number:

Person Responsible (If Patient is a minor, Parent Information is REQUIRED)

Name:	Date of Birth:
Social Security Number:	Phone Number:
Street Address:	
City, State, Zip:	

Emergency Contact

Name:	Relationship:
Home Phone:	Other Phone:

Release

_____ (Initial) I **DO NOT** authorize any information to be disclosed to any other parties except to me as the patient.

_____ (Initial) I **authorize** the person(s) listed below to receive all health information about appointments, treatment, and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Piedmont Eye Associates.

Name/Relationship:	Phone Number:
Name/Relationship:	Phone Number:

Patient Signature: _____ Date: _____

Piedmont Eye Associates

Consent to Use and Disclose Protected Health Information

Use and Disclosure of Your Protected Health Information: Your protected health information will be used by **Piedmont Eye Associates** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices: **Piedmont Eye Associates** is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" brochure provided to you. PLEASE REVIEW IT CAREFULLY.

Requesting a Restriction on the Use or Disclosure of Your Information: You may request a restriction on the use or disclosure of your protected health information. **Piedmont Eye Associates** may or may not agree to restrict the use or disclosure of your protected health information (see authorization).

If **Piedmont Eye Associates** agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent: You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices: **Piedmont Eye Associates** reserves the right to modify the privacy practices outlined in the notice. I understand Piedmont Eye Associates will notify me of these changes via the method I have authorized or upon my next appointment.

Signature: I have reviewed this consent form, received the brochure entitled "Notice of Privacy Policies and Practices" and give my permission to **Piedmont Eye Associates** to use and disclose my health information in accordance with this consent and the notice provided.

I give **Piedmont Eye Associates** permission to access my medication history. _____ (Initials)

_____

Name of Patient (please print)

_____ _____

Signature of Patient (or person authorized to sign for patient) Date

Piedmont Eye Associates

Authorization for Release
Use of Cell Phone, Email & Voicemail Communications

Name: Date of Birth:

Preferred Method of Contact

Please circle one and write the number on the line below:

Home Phone Mobile Phone Other

_____ _____ _____

_____ (Initials) **I grant consent for Piedmont Eye Associates to contact me via wireless telephone calls.** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify Piedmont Eye Associates to the contrary in writing.

_____ (Initials) **I grant consent for Piedmont Eye Associates to contact me via email.** If at any time I provide my email address at which I may be contacted, unless I notify Piedmont Eye Associates to the contrary in writing,

_____ (Initials) **I understand that cell phone, e-mail, and the use of voicemail communications are not secure forms of communication** and that confidentiality of any cell phone, e-mail, and voicemail information cannot be ensured.

**Certain providers in our practice do utilize Patient Portal, an online website where you can access your health information and communicate with our practice in a secure environment. Ask our front office staff if your provider is a participant in Patient Portal and how you can enroll. **

By signing below, I consent to receive communications, including but not restricted to billing and payment for items and services and communication from Piedmont Eye Associates, clinic, hospital, affiliates, contractors, servicers, clinical providers, attorneys, or its agents including collection agencies.

Patient or Patient Representative Signature: _____
Date: _____

PER HIPAA REQUIRMENT, **THIS FORM MUST BE COMPLETED <u>ANNUALLY</u>.**

Piedmont Eye Associates

Medical History and Medications Form

Date: _____ Home Ph: _____ Work Ph: _____

Patient Name: _____

*Primary Care Physician (regular doctor): _____ PCP Phone: _____

*Pharmacy (name, city, street, phone): _____

What is the reason for today's visit? _____

Please answer the following questions about the patient's health – circle all that apply or fill in the blanks.

1. **Medical Conditions** – allergies, anemia, angina, arthritis, arteriosclerosis, asthma, blood transfusion, cancer, colon, diabetes, emphysema, gout, heart disease / heart attack, high blood pressure (hypertension), hyperactivity (ADHD), premature birth (birth weight_____ / gestational age _____ weeks), seizures, stroke, thyroid disease, other: _____
_____

2. **Eye Problems** – cataract, cornea problems, crossed eyes (strabismus), double vision, glaucoma, lazy or wandering eye (amblyopia), macular degeneration, retinal detachment, tearing, dry eye, other: _____
_____
_____

3. **Review of systems – circle all which apply to the patient:**
CONSTITUTIONAL – Headaches, fatigue, fever, weakness, insomnia, weight loss/gain
ENT – hearing loss, ringing in ears, sinus problems, tinnitus, vertigo
RESPIRATORY – asthma, cough, shortness of breath, wheezing, bronchitis, TB
CARDIOVASCULAR – edema, palpitations, chest pain or pressure, irregular heart rate
GASTROINTESTINAL – trouble swallowing, heartburn, abdominal pain, diarrhea, hepatitis
URINARY TRACT – blood in urine, pain or discomfort, bladder or kidney infections, genital sores
SKIN – color changes, rashes, lumps, dry itchy skin, eczema, dermatitis, ulcers, hives, sores
ENDOCRINE – blood sugar - diabetes, weight gain, mass in neck, thyroid problems, weight gain or loss
NEUROLOGIC – headaches, anxiety, numbness, depression, weakness, paralysis, vertigo, seizures
PSYCHOLOGICAL – nervousness, tension, mood swings, irritability, depression, anxiety, nightmares
MUSCULOSKELETAL – joint pain or swelling, stiffness, back pain, muscle aches, cramps, arthritis
HEMATOLOGIC – bruise easily, bleeding, bruising, blood transfusions, anemia, sickle cell disease/anemia
ALLERGY – asthma, hives, seasonal allergies, food allergies, hay fever

4. **Does patient smoke**? Yes / No If yes, how much? _____ # of years_____
Does patient drink? Yes / No If yes, how much? _____ # of years_____

***Continues on next page**

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5. **Family History of medical disease** – cancer, diabetes, heart attack / heart disease, high blood pressure (hypertension), stroke, other: _____
_____
_____

6. **Family History of eye problems** – cataract, cornea problems, crossed eyes (strabismus), glaucoma, lazy or wandering eye (amblyopia), macular degeneration, retinal detachment, other: _____
_____
_____

Medications:

Allergies / _____ NKDA

HX Completed _____/_____/_____ by_____/_____MD
Updated _____/_____/_____ by_____/_____MD
Updated _____/_____/_____ by_____/_____MD
Updated _____/_____/_____ by_____/_____MD
Updated _____/_____/_____ by_____/_____MD
Updated _____/_____/_____ by_____/_____MD