WELCOME TO OUR OFFICE

Stephens County Eye Clinic **Kevin Vanderhoef, O.D.**

The information in this confidential case history form is critical to the evaluation of your vision and health.

Today's Date _________________

Last: ________________________ **First:** __________________________ **MI:**_____________

Street: ____

City: _________________________ **State:** _____________________ **Zip Code:** ___________

Home Phone: _____________________ **Day Phone:** ____________________

Cell Phone: _______________________ **Email Address:** ______________________________

How do you wish to be reached: Telephone: ______ **Email:** _______ **Postal:**_____

Date of Birth: _____________________ **Age:** __________ **Sex: Male**____ **Female**____

Height: _______________ **Weight:** _________________

Race: White __ **Hispanic** __ **African American** __ **Asian** __ **Native Hawaiian** __ **Other**__

Preferred Language: __ **English** __ **Spanish**

Patient's Social Security Number: ________________________________

Employer (or School): ____

Occupation (or Grade): ____

Spouse (or Parent's Name): ________________**Spouse (or Parent's Work):** _____________

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?

Name of friend or relative: _______________________ **Doctor:** ________________________

If not referred, how did you choose our office for your needs?

Saw Sign/Building: _________________ **Yellow Pages: Which Directory:** ____________

Newspaper/Radio/TV: ________________ **Other** _________________________________

STEPHENS COUNTY EYE CLINIC

Name: ________________________ DOB: ___________ SS#: ____________ Phone:______________

MEDICAL HISTORY:

____

Reason for your visit today:

____

Referred By: ________________________ Medical Doctor: ___________________________

Past Medical History: Circle Any Illnesses You Have Had:

DIABETES	CANCER	HIGH BLOOD PRESSURE
STROKE	HEPATITIS	THYROID DISEASE
HEART ATTACK	HEART FAILURE	HEART RHYTHM PROBLEM
ARTHRITIS	ASTHMA	OTHER: ___________________
GLAUCOMA	CATARACTS	OTHER: ___________________

MEDICATIONS

NAME: STRENGTH: DOSAGE:

___________________________ _____________________________ _____________________

___________________________ _____________________________ _____________________

LIST ADDITIONAL ON BACK.

ALLERGIES TO MEDICATIONS:

YES: ____

____

LIST ADDITIONAL ON BACK.

SURGERIES &/OR HOSPITALIZATIONS: REASON:

____ __________________________________

____ __________________________________

LIST ADDITIONAL ON BACK.

EYE INJURIES: REASON:

____ ___________________________________

____ ___________________________________

STEPHENS COUNTY EYE CLINIC

FAMILY HISTORY: ANY DISEASE IN THE FAMILY? CIRCLE “YES” OR “NO”. IF YES, INDICATE RELATIONSHIP

DISEASES:			RELATIONSHIP TO PATIENT:
BLINDNESS	YES	NO	___________________________
CATARACT	YES	NO	___________________________
GLAUCOMA	YES	NO	___________________________
MACULAR DEGNERATION	YES	NO	___________________________
RETINAL DETACHMENT	YES	NO	___________________________
ARTHRITIS	YES	NO	___________________________
CANCER	YES	NO	___________________________
DIABETES	YES	NO	___________________________
HEART ATTACKS	YES	NO	___________________________
HIGH BLOOD PRESSURE	YES	NO	___________________________
KIDNEY DISEASE	YES	NO	___________________________
STROKE	YES	NO	___________________________
THYROID DISEASE	YES	NO	___________________________
OTHER	YES	NO	___________________________

SOCIAL HISTORY:

MARITAL STATUS: CIRCLE ONE

SINGLE MARRIED WIDOWED DIVORCE

PRESENT OCCUPATION: ____

DO YOU DRINK ALCOHOL? YES _____ NO _____ IF YES, HOW MUCH PER DAY ______________

DO YOU SMOKE OR USE OTHER TOBACCO PRODUCTS? YES ____ NO ____ HOW MUCH PER DAY? ________

HAVE YOU EVER BEEN DIAGNOSED WITH AN STD? YES _____ NO _____

REVIEW OF SYSTEMS: DO YOU PRESENTLY HAVE ANY PROLEMS IN THE FOLLOWING AREAS?

SYSTEM:			EXPLANATION OF PROBLEM
SKIN	YES	NO	_______________________________
HEAD	YES	NO	_______________________________
EARS,NOSE,MOUTH,THROAT,NECK	YES	NO	_______________________________
RESPIRATORY	YES	NO	_______________________________
CARDIOVASCULAR (HEART)	YES	NO	_______________________________
GASTROINTESTINAL (STOMACH/INTEST.)	YES	NO	_______________________________
REPRODUCCTIVE ORGANS	YES	NO	_______________________________
BONES,JOINT, MUSCLES	YES	NO	_______________________________
NEUROLOGIC	YES	NO	_______________________________
LYMPHATICE (LYMPH NODES/SWELLING)	YES	NO	_______________________________
HEMATOPOIETIC (BLOOD)	YES	NO	_______________________________
ALLERGIES	YES	NO	_______________________________
PSYCHIATRIC	YES	NO	_______________________________

INSURANCE INFORMATION: ____

STEPHENS COUNTY EYE CLINIC

IS THIS VISIT WORK RELATED: YES ____ NO ____ DATE OF INJURY: ________________________
HOW DID THE ACCIDENT OCCUR? ____
____

PLEASE GIVE US YOUR INSURANCE CARDS TO COPY. THIS INFORMATION WILL ASSIST US IN FILING YOUR INSURANCE, BUT DOES NOT RELIEVE YOU OF YOUR OBLIGATION TO PAY ANY BILL INCURRED FOR SERVICES.

MY SIGNATURE BELOW INDICATES THAT ALL INFORMATION COMPLETED IS TRUE TO THE BEST OF MY KNOWLEDGE. ADDITIONALLY, I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS A CLAIM. I REQUEST PAYMENT OF GOVERNMENT OR PRIVATE INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT ON A CLAIM. THIS AUTHORIZATION IS VALID UNLESS I NOTIFY THE PHYSICIAN OF A CHANGE.

SIGNATURE: ____ DATE: ____________________

HIPPA PRIVACY AUTHORIZATION

PATIENT NAME: ___________________________________ D.O.B: _______________________

I HAVE AGREED TO LET CERTAIN INDIVIDUALS PARTICIPATE IN DISCUSSIONS AND DECISIONS RELATED TO MY MEDICAL CARE. THEREFORE, I HEREBY GIVE PERMISSION FOR STEPHENS COUNTY EYE CLINIC/FRANKLIN COUNTY EYE CARE, DR. VANDERHOEF, AND HIS STAFF TO DISCLOSE MY PERSONAL MEDICAL INFORMATION TO THE FOLLOWING INDIVIDUALS.

NAME: __________________________________ RELATIONSHIP TO PATIENT: ____________________
PHONE NUMBER: ________________________

NAME: __________________________________ RELATIONSHIP TO PATIENT: ____________________
PHONE NUMBER: ________________________

NAME: __________________________________ RELATIONSHIP TO PATIENT: ____________________
PHONE NUMBER: ________________________

NAME: __________________________________ RELATIONSHIP TO PATIENT: ____________________
PHONE NUMBER: ________________________

CONDITIONS FOR DISCLOSURE:

_______ THE PRACTICE MAY DISCLOSE MY PERSONAL HEALTH INFORMATION TO THE INDIVIDUALS ABOVE ONLY IN MY PRESENCE.

_______ THE PRACTICE MAY DISCLOSURE MY MEDICAL INFORMATION TO INDIVIDUALS ABOVE IN DISCUSSIONS IN MY PRESENCE AND WHEN I AM NOT PHYSICALLY PRESENT, INCLUDING DISCLOSURES BY TELEPHON, FACSIMILE, EMAIL, OR REGULAR MAIL.

_______ OTHER CONDITIONS FOR DISCLOSURE: ____

THIS PERMISSION WILL REMAIN IN EFFECT UNTIL SUCH TIME THAT THE PATIENT LISTED ABOVE NOTIFIES US IN WRITING.

PATIENT SIGNATURE: ____ DATE: ______________

STEPHENS COUNTY EYE CLINIC

Consent to use disclosure health information for treatment payment, and health care options

PATIENTS NAME: ________________________________ D.O.B: _______________

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office. We have a comprehensive Notice of Privacy Practices that describes the uses and disclosure in detail. You are free to refer to this notice at any time before you sign this Consent Form. As described in our Notice of Privacy Practices, the use and disclosure of your health information for th treatment purposes not only includes care and service provided here, but also disclosure of your health informationas may be necessary or appropriate for purposes of follow-up care from another health professional. Similarly the use and disclosure of your health information for purposes of payment includes (1) our submission of health informationto a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to a third party payer or insurer for claims review, determination of benefits and payment; (3) our submissionof your health information to auditors hired by third party payers and insurers; and (4) other aspects of payment decribed in our Notice of Privacy Practices will be updated whenever our privacy practices changes. You can get an updated copy here at the office.

When you sign this document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perfom health care operations. You can revoke this consent in writing at any time unless we already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. You have the right to ask us to restrict the uses of disclosures made for purposes of treatment, payment, or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I have read this consent and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment, and health care operations.

SIGNATURE: ____ DATE: ___________________
If signing as a person representative of the patient, describe the relationship to the patient and the source of the authority to sign this form:

Relationship to patient: _____________________ Print Name: ____________________________