Refraction Service and Fee

A refraction is the test done to determine your prescription you will need to obtain corrective eyeglasses or contact lenses. If a refraction is not performed, a prescription for glasses or contact lenses cannot be provided to you.

Most medical insurance plans, including Medicare, **do not pay** for all of your health care costs, **including the cost of performing a refraction**. Some items and services, such as refraction, are not considered "covered" benefits, and neither medical insurance nor Medicare will pay for them.

If you are having a medical exam performed today but also wish to update your glasses or contact lens prescription, you have the option of having only the medical portion of your visit completed which will be billed to your medical insurance. You may then make another appointment to return for a refraction so that the refraction can be billed to your vision insurance. Your vision insurance usually covers 1 exam with refraction per year.

If you do decide during your medical exam today that you would like a current prescription for glasses or contact lenses, you will be charged the $45 refraction fee.

_____Yes I would like a refraction done today and I understand I will pay the $45 fee today

_____No I do NOT want a refraction done today

Patient Acknowledgement

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at the time of service.

I understand that any copayment, coinsurance, or deductible I may have is separate from and not included in the refraction fee.

_____ _____

Patient Signature (Parent for minor) Date

choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

  We are required to agree to your request if you pay for treatment, services, supplies and prescriptions "out of pocket" and you request the information not be communicated to your health plan for payment or health care operations purposes. There may be instances where we are required to release this information if required by law.

  To request restrictions, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information to our Privacy Officer.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you may complete and submit a request for restriction on use/ disclosure of medical information and/or confidential communication to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our office during normal business hours.

- **Right to Choose Another to Act For You.** You have the right to assign another the authority to act on your behalf (medical power of attorney, legal guardian). That person will be able to exercise your rights and make choices about your health information. However, we will need legal proof this person has the authority to act for you before we take any action.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice, and to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current Notice at our location(s) with its effective date in the bottom left hand corner. You are entitled to a copy of the Notice currently in effect.

We will inform you of any significant changes to this Notice. This may be through our newsletter, a sign prominently posted at our location(s), a Notice posted on our web site or other means of communication.

BREACH OF HEALTH INFORMATION

We will inform you if there is a breach of your unsecured health information.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services.

To file a complaint with the Department of Health and Human Services, send a letter to:

200 Independence Ave, S.W., Washington, D.C. 20201, by calling 1-877-696-6775, or by visiting www.hhs.gov/orc/privacy/hipaa/complants/

To file a complaint with Mid Ohio Eye, contact our Privacy Officer, Ashley San Filippo, MD in writing at: 4830 Knightsbridge Blvd., Suite G, Columbus, Ohio 43214.

You will not be penalized for filing a complaint.

Effective: April 14, 2003
Revised: November 12, 2019

MID OHIO EYE *Physicians & Surgeons*

NOTICE OF PRIVACY PRACTICES

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.**

If you have any questions about this Notice, please contact our Privacy Officer, Ashley San Filippo, MD by calling 614-488-8000 or by writing to 4830 Knightsbridge Blvd., Suite G, Columbus, Ohio 43214

WHO WILL FOLLOW THIS NOTICE

This Notice describes the information privacy practices followed by our employees, staff and other personnel.

YOUR HEALTH INFORMATION

This Notice applies to the information and records we have about you, your health, health status, and the health care and services you receive from Mid Ohio Eye. Your health information may include information created and received by Mid Ohio Eye, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this Notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

- **For Treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, staff or other personnel who are involved in taking care of you and your health.

  For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

  Different personnel in our organization may share information about you and disclose information to people who do not work for Mid Ohio Eye in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition.

- **For Payment.** We may use and disclose health information about you so that the treatment and services you receive at Mid Ohio Eye may be billed to and payment may be collected from you, an insurance company or a third party.

  For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will pay for the treatment.

- **For Health Care Operations.** We may use and disclose health information about you in order to run the practice and make sure that you and our other patients receive quality care.

  For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

  We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

- **For Fund Raising.** We may contact you to ask for your help with different fund raising campaigns. Please notify us if you do not wish to be contacted during fund raising campaigns. If you advise us **in writing** (at the physical or email address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.
- **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
- **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.
- **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
- **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
- **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room or the hospital during treatment or while treatment is discussed.

  In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. Examples of disclosures requiring your authorization include disclosures to your spouse, your partner, your children and your legal counsel. In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as psychotherapy notes, HIV, substance abuse, mental health, and genetic testing information for purposes such as treatment, payment and healthcare operations.

If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, **in writing**, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to our Privacy Officer and request to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your medical record.

  If you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit your request **in writing** to our Privacy Officer. You have the right to request a copy of your health information in electronic form if we store your health information electronically.

  We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.
- **Right to Amend.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is being kept by Mid Ohio Eye.

  To request an amendment, complete and submit a letter describing the medical record amendment/correction requested to our Privacy Officer.

  We may deny your request for an amendment if your written request does not include a reason to support the request. In addition, we may deny or partially deny your request if you ask us to amend information that:
  - We did not create, unless the person/entity that created the information is no longer available to make the amendment
  - Is not part of the health information that we keep
  - Is accurate and complete based solely on our medical judgment

  If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request the rebuttal be made a part of your medical record. Your rebuttal needs to be two pages in length or less and we have the right to file a rebuttal responding to yours in your medical record. You also have the right to request that all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the medical record is disclosed.
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, when specifically authorized by you and a limited number of special circumstances involving national security, correctional institutions and law enforcement.

  To obtain this list, you must submit your request **in writing** to our Privacy Officer. It must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may

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PATIENT REGISTRATION FORM

PLEASE PRINT

Patient Name _____ (LAST) _____ (FIRST) _____ (MI) **DOB** ___/___/_____

SSN: _____ **Gender:** [ ] M [ ] F **Marital Status:** [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Demographic Information

Race: [ ] American Indian/Alaskan Native [ ] Asian [ ] African American [ ] Caucasian
[ ] Hispanic/Latino [ ] Native Hawaiian or Other Pacific Islander [ ] Other _____

Patient Contact Information

Mailing Address:		
City:	State:	Zip:
Email Address:	Home Phone: (___) ___ - ____	
Employer Name:	Cell Phone: (___) ___ - ____	
Employer Address:	Work Phone: (___) ___ - ____	Ext: ___
City:	State:	Zip:

Emergency Contact Name: _____ Relation: _____ Phone: (___) ___ - ____
Name: _____ Relation: _____ Phone: (___) ___ - ____

For Minor Patients (If Applicable)

Responsible Party:		Relation:	
Address:		Phone Number: (___) ___ - ____	
City:	State:	Zip:	DOB: ___/___/_____

Doctor Information

Primary Care Physician: _____ Location: _____

Eye Care Provider: _____ Location: _____

Consent for Treatment Involvement

Please list family members or friends with whom we may discuss your treatment and medication decisions or payment for your care: [ ] No One [ ] Yes. List name and relationship: _____

Text Messaging and Voice Mail Consent

Text Message: [ ] YES [ ] NO Voice Mail: [ ] YES [ ] NO Messaging could include non-medical information and appointment reminders. Please note we will ONLY communicate for medical reasons as outlined by HIPAA.

By signing below:

1) I acknowledge that I have been informed of the HIPAA Privacy Practices and have been offered a copy;
2) I acknowledge that I have been informed of the Patient Financial Policy and have been offered a copy;
3) I am aware that I can obtain copies of these documents in the office and on the Mid Ohio Eye website;
4) I agree that all information given above is true to the best of my knowledge;
5) I agree that I am responsible for notifying Mid Ohio Eye of any changes in my demographic information, and understand and agree to allow up to 2 weeks for Mid Ohio Eye to update any changes made to my preferences;
6) I authorize my insurance benefits be paid directly to the physician, and I authorize my insurance company to release any information required to process my claims.

How were you referred to us?

[ ] Doctor Referral (please list) _____ [ ] Insurance [ ] TV/Radio [ ] Social Media
[ ] Friend / Relative _____ [ ] Other _____

Patient Signature: _____ Date: _____

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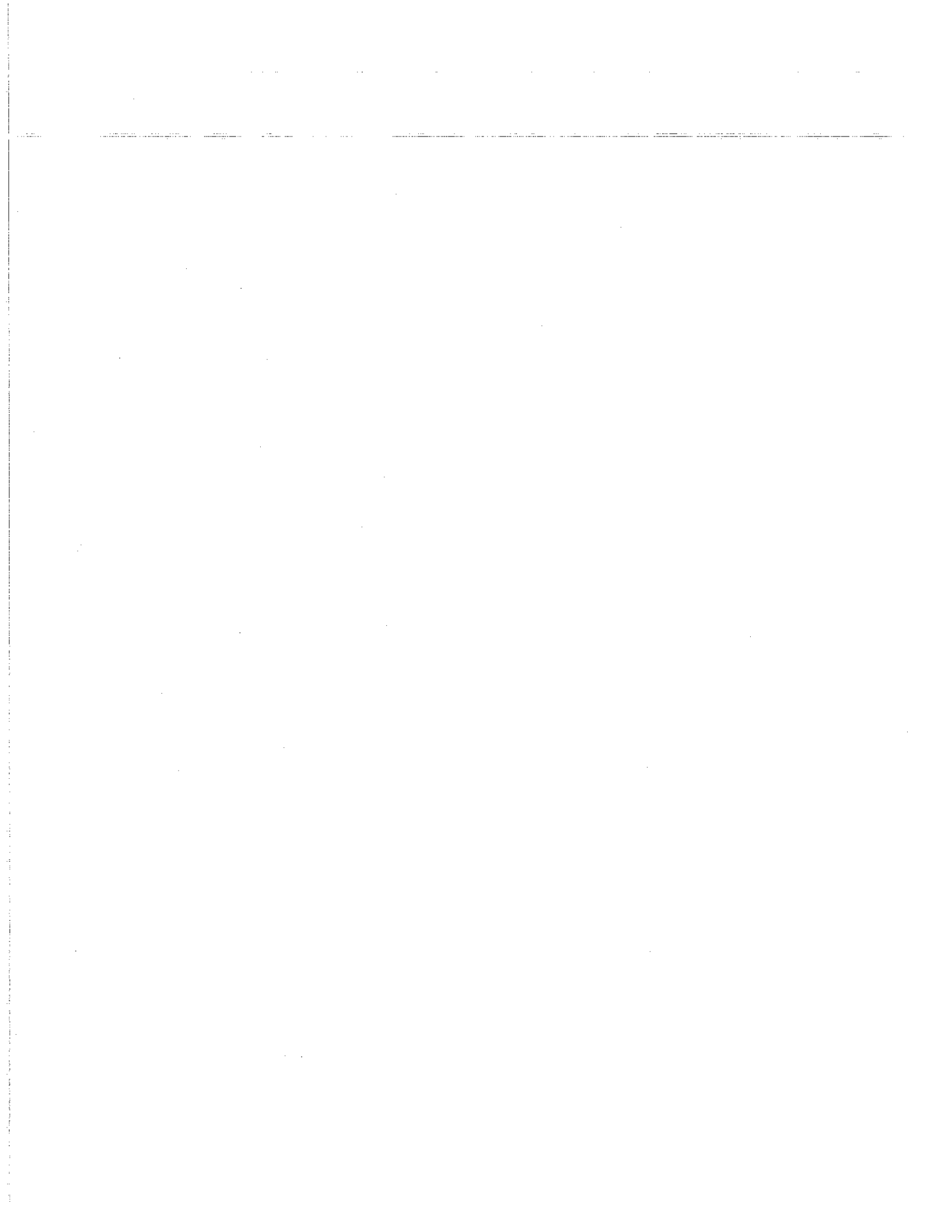

Our Patient Financial Policy

Thank you for choosing Mid Ohio Eye to serve your healthcare needs. We are committed to your successful treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment. Our practice firmly believes that a good physician and patient relationship is based upon understanding and good communication. We believe that an informed consumer is a more satisfied patient. Therefore, we want to communicate our Patient Financial Policy to you in writing so that you will know what to expect at the time of your visit.

Insurance

All patients must complete our patient registration form and provide current information before being seen by the doctor. We accept assignment from many medical and vision insurance companies, but in the event that your insurance does not cover your visit or treatment within a reasonable time (45-60 days) the balance may automatically be transferred to the patient's responsibility. Please be aware that some of the services provided may be non-covered services and considered not reasonable and necessary under Medicare and/or other medical insurance guidelines.

We must emphasize that as medical care providers, **our relationship is with you, not your insurance company**. We will appeal disputed claims with insurance companies to the extent additional documentation is required from us in order for your claim to be processed. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of what those rates should be.

All co-pays, deductible, and balances owed are due at time of service. If your insurance applies any of your charge to your annual deductible or coinsurance, that portion is due and payable by you at the time of service. If you have elected to use our practice and our physicians out of your network of coverage please check with your insurance regarding benefit levels. Your employer or provider of insurance determines your benefit coverage by contracting with a particular insurance company. If you have questions regarding your coverage, please speak with your human resources representative or use the payer web address listed on your card. **It is your responsibility to understand your benefit coverage.**

High Deductible Health Plans (HSA, HRA, FSA participants)

Please inform us prior to your visit if you are a participant in a High Deductible Health Plan (HDHP), a Health Savings Account (HSA), a Health Reimbursement Arrangement (HRA) or a Flexible Spending Account (FSA). You must be prepared with the plan information and **pay the patient responsible portion** from the HSA, HRA or FSA **at the time of service.**

Patient Responsibility

If you are seeking a non-covered service, do not have insurance, or if you are a participant in an insurance for which we are not a provider, we require that you be prepared to pay our fees at the time services are rendered. Please inquire with our staff about self pay cash discounts for payment at the time of service. If you are covered by insurance your bill will be reduced to our contracted allowable amount.

We realize that temporary financial problems may affect timely payment on your account. If such problems arise, or in circumstances where a claim is pending or when treatment will be provided for an extended period of time, it is recommended that a payment plan be initiated. We encourage you to contact our billing office at (888) 572-1181 for prompt assistance in the management of your account.

Payment Details

We accept cash, check, and most major credit cards. We have the capability to accept payments over the phone with your debit or credit account information. We reserve the right to process your payment electronically based on information you provide to us.

If you are having surgery, the surgery center and anesthesiologist are separate providers from us. Payment for services performed at any facility outside our office needs to be discussed with that facility.

Any returned checks are subject to a $35.00 fee. Returned checks must be resolved before any future appointments can be scheduled.

Minor Aged Patients

Adults accompanying minor patients (parents or guardians) will need to complete a Release of Liability and Permission form. The parent or guardian accompanying the minor is responsible for payment of any fees for that minor not covered by insurance. For unaccompanied minors, treatment will be denied unless we have received the proper paperwork. Insurance cards need to list the minor's name.

Missed Appointments

We ask that if you are unable to keep an appointment, that you call us as early as possible to reschedule. In order to provide the best possible service and availability to all our patients, it is our policy that if you miss three or more appointments, we may refuse to continue providing care to you.

Account Delinquency and Credit Reporting

An account is considered delinquent and may be referred for collections if payment in full is not made in a timely manner. If you are unable to adhere to an original payment agreement you must contact us to discuss alternative arrangements. If payment arrangements are not made and/or payment in full is not made, your account with us would be referred to collections, and your credit history may be obtained.

We also reserve the right to bill a collections fee in addition to the outstanding amounts owed for services rendered. All outstanding balances must be paid off in order for future visits to be scheduled. If not resolved in a timely manner, we reserve the right to dismiss you from our practice.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Name of Patient or Guarantor	Signature	Date
Employee Name (Witness)	Signature	Date

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PATIENT HISTORY FORM

Today's Date: _____

Patient Name: _____ Date of Birth: ___/___/___

Pharmacy: _____ Street address: _____

History Of Latex Allergy? [ ] Yes [ ] No Have you or any family members had an adverse anesthesia reaction: [ ] Yes [ ] No

Occupation: _____ Age: _____ Height: _____ Ft. _____ In. Weight: _____ Lbs

What is the reason for today's visit? _____

DO YOU HAVE ANY OF THESE SYMPTOMS	☐ Flashing lights or floaters	☐ Foreign body sensation
☐ Blurred distance vision	☐ Glare, halos around lights	☐ Eye mattering or tearing
☐ Blurred reading vision	☐ Itching or burning eyes	☐ Dry eyes
☐ Constant double vision	☐ Eye pain	☐ Red Eye

OCULAR HISTORY

Past Ocular History: (Check Which Eye)	[ ] Cataracts	[ ] R [ ] L	[ ] Glaucoma	[ ] R [ ] L
	[ ] Double Vision	[ ] R [ ] L	[ ] Retinal tear/ Detachment	[ ] R [ ] L
	[ ] Strabismus	[ ] R [ ] L	[ ] Shingles / Zoster	[ ] R [ ] L
	[ ] Dry eyes	[ ] R [ ] L	[ ] Amblyopia / Lazy eye	[ ] R [ ] L
[ ] No Past Eye History	[ ] Sjogren's	[ ] R [ ] L	[ ] Recurrent Corneal Erosion	[ ] R [ ] L
	[ ] Corneal Abrasion	[ ] R [ ] L	[ ] Trauma/ Foreign Body/ Scar	[ ] R [ ] L
	[ ] Keratoconus, you / family	[ ] R [ ] L	[ ] Corneal Disease	[ ] R [ ] L
	[ ] Macular Degeneration	[ ] R [ ] L	[ ] Floaters	[ ] R [ ] L
Past Ocular Surgery: (Check Which Eye)	[ ] PRK	[ ] R [ ] L	[ ] Glaucoma Surgery	[ ] R [ ] L
	[ ] RK / AK	[ ] R [ ] L	[ ] Retinal Surgery	[ ] R [ ] L
	[ ] LASIK	[ ] R [ ] L	[ ] Cataract Surgery	[ ] R [ ] L
[ ] No Past Eye Surgery	[ ] Muscle Surgery	[ ] R [ ] L	[ ] Other: _____	[ ] R [ ] L
	[ ] Corneal Transplant	[ ] R [ ] L	_____	

Do you wear glasses regularly? [ ] Yes [ ] No
If yes, how old are they?_____ Do you want to be checked for glasses today? [ ] Yes [ ] No

Contact Lens History:	[ ] No contact lenses	[ ] Soft overnight	[ ] Soft Toric	[ ] Soft daily
If you wear contact lenses	[ ] Monovision Lenses	[ ] Bifocal lenses	[ ] RGP, years worn:____	[ ] Scleral
When were they last worn?	History of difficulty with contact lens wear? [ ] Y [ ] N Please explain: _____			

MEDICAL HISTORY (CHECK ALL THAT APPLY)

[ ] Allergies	[ ] Gout	[ ] Osteoporosis
[ ] Alzheimer's	[ ] Headaches / Migraines	[ ] Parkinson's
[ ] Anemia	[ ] Hearing Loss	[ ] Melanoma
[ ] Arthritis type:_____	[ ] Heart Attack	[ ] Rosacea
[ ] Asthma	[ ] Heart Disease	[ ] Schizophrenia
[ ] Atrial Fibrillation	[ ] High Blood Pressure	[ ] Sleep Apnea: Do you use a C-pap [ ] Yes [ ] No
[ ] Cancer type: _____	[ ] High Cholesterol	[ ] Stroke
[ ] COPD	[ ] HIV	[ ] Thyroid Disorder [ ] Hyper [ ] Hypo
[ ] Dementia	[ ] IBS	[ ] Tuberculosis (TB) [ ] Active [ ] Inactive since_____
[ ] Depression	[ ] Liver Disease	[ ] Other medical Conditions:_____
[ ] Diabetes type [ ] 1 [ ] 2	[ ] Lupus	_____
[ ] Enlarged Prostate	[ ] Mitral Valve Prolapse	_____
[ ] Epilepsy	[ ] Multiple Sclerosis	[ ] List Surgeries and Trauma: _____
[ ] Fibromyalgia	[ ] MRDD	_____
[ ] GERD	[ ] Obesity	_____

Patient Name: _____ Date of Birth: ___/___/___

FUNCTIONAL STATUS: [ ] Impaired [ ] Not Impaired **ADA:** [ ] Perform tasks without assistance [ ] Need assistance

FAMILY HISTORY		RELATIONSHIP			RELATIONSHIP
[ ] Yes [ ] No	High blood pressure	_____	[ ] Yes [ ] No	Cataracts	_____
[ ] Yes [ ] No	Diabetes	_____	[ ] Yes [ ] No	Retinal Disease	_____
[ ] Yes [ ] No	Cancer	_____	[ ] Yes [ ] No	Macular Degeneration	_____
[ ] Yes [ ] No	Glaucoma	_____	[ ] Yes [ ] No	Keratoconus	_____

SOCIAL HISTORY

Tobacco Use: [ ] Never [ ] Former [ ] Current Amount: _____ Recreational Drugs: [ ] Yes [ ] No
Alcohol: [ ] Yes [ ] No Amount: _____

Name of Medication	Strength / Dose	How often taken / Route	Reason for taking
Please list prescribed and over-the-counter medications you are currently taking, include vitamins and supplements			
Example: Celebrex	Example: (1) 100 mg	Example: Twice a day, by mouth	Example: Arthritis
Medication Allergies and Reactions:			

REVIEW OF SYSTEMS - Please check all that *CURRENTLY* apply				
Constitutional	[ ] Cough	[ ] Nausea	[ ] Numbness/tingling	**Psychiatric**
[ ] Chronic Fatigue Syndrome	[ ] COPD	[ ] Vomiting	[ ] Paralysis	[ ] Anxiety
[ ] Fever	[ ] Lung cancer	**Genitourinary**	[ ] Stroke	[ ] Depression
[ ] Night Sweats	[ ] Sleep apnea	[ ] Cystitis	[ ] Learning disability	[ ] Bipolar
[ ] Weight loss	[ ] Shortness of breath	[ ] Enlarged Prostate	[ ] Headaches	[ ] Panic attacks
[ ] Weight gain	[ ] Wheezing	[ ] Frequent urination	[ ] Parkinson's	[ ] Paranoia
Integumentary (Skin)	**Cardiovascular**	[ ] Difficulty urinating	[ ] Seizures	[ ] Schizophrenia
[ ] Breast Cancer	[ ] Chest pain	[ ] Kidney Disease	**Endocrine**	**Allergy/Immunologic**
[ ] Skin Cancer	[ ] CHF	[ ] Prostate cancer	[ ] Cold intolerance	[ ] Seasonal allergies
[ ] Dryness	[ ] Fast or irregular	**Musculoskeletal**	[ ] Heat intolerance	[ ] Hay fever
[ ] Jaundice	heart beat	[ ] Arthritis	[ ] Excessive thirst	[ ] Persistent infection
[ ] Rosacea	[ ] Heart disease	[ ] Back pain	[ ] Diabetes	**MRSA**
[ ] Eczema	[ ] Heart attack	[ ] Gout	[ ] Insulin pump	[ ] Carrier
[ ] Psoriasis	**Gastrointestinal**	[ ] Osteoporosis	[ ] Thyroid Disorder	[ ] Current issues
ENT	[ ] Colitis	[ ] Joint pain	**Hematological /**	**Hepatitis**
[ ] Dry mouth / throat	[ ] Constipation	[ ] Muscle weakness	**Lymphatic**	[ ] A
[ ] Dizziness	[ ] Diverticulitis	[ ] Lupus	[ ] Anemia	[ ] B
[ ] Ear pain / Ringing	[ ] Diarrhea	**Neurological**	[ ] Easy bruising	[ ] C
[ ] Sinus problems	[ ] GERD	[ ] Fainting	[ ] Prolonged bleeding	
[ ] Hearing loss	[ ] IBS	[ ] Alzheimer's	[ ] AIDs	**Are you currently**
Respiratory	[ ] Heartburn	[ ] Confusion	[ ] HIV	[ ] Pregnant
[ ] Allergies	[ ] Crohn's disease	[ ] Multiple Sclerosis	[ ] Sarcoidosis	[ ] Nursing
[ ] Asthma	[ ] Jaundice	[ ] Memory Loss	[ ] Leukemia	