PATIENT HISTORY FORM

Last Name _____
First Name _____
Address _____
City _____
State & Zip _____
Home Phone _____
Work Phone _____
Work Place _____
E-Mail _____
Emergency Contact _____
Date of Last Exam _____

Responsible Party _____
Medicaid # _____
Medicare # _____
Date of Birth _____
Age _____
Occupation _____
Eye Insurance _____
Insurance # _____
Social Security # _____
Name on Insurance _____
By Whom _____

Reason for Today's Exam _____
Contact Lens Type _____
Age of Lenses _____

Would you like to try contacts? ____ Yes ____ No

Please check any condition that applies to yourself or any members of your immediate family:

	Self	*Family*		*Self*	*Family*
Diabetes	_____	_____	Retinal Detachment	_____	_____
High Blood Pressure	_____	_____	Eye Surgery	_____	_____
Cataracts	_____	_____	Lazy Eye	_____	_____
Heart Problems	_____	_____	Double Vision	_____	_____
Respiratory Problems	_____	_____	Blindness	_____	_____
Thyroid Problems	_____	_____	Head/Eye Injury	_____	_____
Glaucoma	_____	_____	Headaches	_____	_____

Medications you are currently taking _____

What allergies do you have, if any? _____

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

In the course of providing serve 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 these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our website. When you sign this consent 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 perform health care operations. You can revoke this consent in writing at any time unless we have 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. We can decline to serve you if you elect not to sign this consent. You have a right to ask us to restrict the uses or 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 these 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 PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

_____ _____

Signature *Date*

I request that payment of authorized Medicare benefits be made on my behalf to me, for services furnished by Dr. Karen Gorman. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

_____ _____

Signature *Date*