NAME _____ PHONE _____

ADDRESS _____ MOBILE [__] HOME [__]

_____ TEXTING OK Y or N

EMAIL ADDRESS _____ OCCUPATION _____

SEX [ ] M [ ] F AGE _____ BIRTHDATE _____ [ ] SINGLE [ ] MARRIED [ ] WIDOWED

IF UNDER 18 NAME OF PARENT/GUARDIAN: _____

VISION PLAN

NAME OF INSURANCE _____ ID NUMBER _____

SUBSCRIBER'S NAME _____ RELATIONSHIP TO SUBSCRIBER _____

SUBSCRIBER'S DATE OF BIRTH _____

HEALTH INSURANCE

NAME OF INSURANCE _____ ID NUMBER _____

SUBSCRIBER'S NAME _____ RELATIONSHIP TO SUBSCRIBER _____

SUBSCRIBER'S DATE OF BIRTH _____

PRIMARY CARE PHYSICIANS NAME: _____

HOW DID YOU HEAR ABOUT US? _____

WHAT ACTIVITIES DO YOU SPEND A LOT OF TIME DOING?

[ ] DRIVING [ ] READING [ ] TV ***COMPUTER USE*** _____ ***HOURS PER DAY***

[ ] CONTACT SPORTS [ ] HUNT [ ] FISH [ ] GARDEN [ ] OTHER _____

DO YOU WEAR GLASSES? ..... [ ] ALL DAY [ ] ON AND OFF [ ] NO

ARE YOU INTERESTED IN WEARING CONTACT LENSES? ..... [ ] YES [ ] NO

CONTACT LENSES [ ] _____ HRS PER DAY _____ DAYS PER WK _____ TYPE OF CONTACT LENS SOLUTION

DO YOU SLEEP WITH YOUR CONTACTS [ ] Y [ ] N _____ DAYS PER WEEK _____ DAYS PER MONTH

REPLACEMENT SCHEDULE: [ ] DAILY [ ] WEEKLY [ ] BI-WEEKLY [ ] MONTHLY [ ] OTHER _____

MEDICAL HISTORY: PLEASE CHECK CONDITIONS YOU HAVE OR HAD IN THE PAST:

[ ] DIABETES
[ ] HEART CONDITION
[ ] HIGH BLOOD PRESSURE
[ ] STROKE
[ ] CANCER TYPE _____
[ ] MACULAR DEGENERATION
[ ] CATARACTS
[ ] GLAUCOMA
[ ] RETINAL DISEASE
[ ] POOR COLOR VISION
[ ] LAZY EYE
[ ] HIGH CHOLESTEROL
[ ] HEADACHES

[ ] ASTHMA
[ ] HEPATITIS
[ ] HIV VIRUS
[ ] PREGNANT NOW
[ ] THYROID CONDITION
[ ] PREMATURE BIRTH
[ ] DOUBLE VISION
[ ] EYE INFECTION
[ ] EYE INJURY
[ ] DRY EYE
[ ] EYES WATER
[ ] OTHER _____
[ ] ARTHRITIS

[ ] SEEING HALOS
[ ] FLOATERS
[ ] FLASHES
[ ] SENSITIVITY TO LIGHT
[ ] BLURRED VISION
{ } DISTANCE W/GLASSES { } DISTANCE W/OUT GLASSES
{ } NEAR W/GLASSES { } NEAR W/OUT GLASSES
[ ] ALLERGIES
SPRING FALL ALL YEAR
[ ] I SMOKE _____ PACKS PER DAY
[ ] CONSUME ALCOHOL _____ DRINKS PER WEEK
[ ] EYE SURGERY _____

FAMILY HISTORY PLEASE CIRCLE TO INDICATE RELATIONSHIP MOTHER (M) - FATHER (F) - SISTER (S) - BROTHER (B)- MATERNAL/PATERNAL GRANDFATHER (MGF) (PGF) - MATERNAL/PATERNAL GRANDMOTHER (MGM, PGM)

[ ] HEART CONDITION M F S B MGF PGF MGM PGM
[ ] HIGH BLOOD PRESSURE M F S B MGF PGF MGM PGM
[ ] RETINAL DISEASE M F S B MGF PGF MGM PGM
[ ] POOR COLOR VISION M F S B MGF PGF MGM PGM
[ ] HIGH CHOLESTEROL M F S B MGF PGF MGM PGM
[ ] MACULAR DEGENERATION M F S B MGF PGF MGM PGM

[ ]GLAUCOMA M F S B MGF PGF MGM PGM
[ ]CANCER M F S B MGF PGF MGM PGM
[ ]DIABETES M F S B MGF PGF MGM PGM
[ ]STROKE M F S B MGF PGF MGM PGM
[ ]CATARACTS M F S B MGF PGF MGM PGM
[ ] LAZY EYE M F S B MGF PGF MGM PGM

LIST ALLERGIES YOU HAVE TO **MEDICATIONS AND REACTION** _____

LIST THE **MEDICATIONS/VITAMINS/HERBS** YOU ARE PRESENTLY TAKING _____

PLEASE GIVE YOUR VISION INSURANCE PLAN AND HEALTH INSURANCE CARD TO THE FRONT DESK STAFF WITH THIS FORM -- THANK YOU **DATE** _____

CATSKILL EYE CARE ASSOCIATES
5532 STATE HIGHWAY 7
ONEONTA, NEW YORK 13820
607-432-2600

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.
I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.
I understand, upon my signature below that this ***Consent Form*** can and will be used to obtain my medical records from my previous Provider.

Signature:_____
(Patient or Guardian) Relationship to Patient

Patient Name: _____

Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

Patient Acknowledgment

I hereby acknowledge, upon my signature above, receipt of a copy of Catskill Eye Care Associates "**HIPAA Notice of Privacy Practices**".

PRESCRIPTION WAVIER ACKNOWLEDGMENT

I hereby acknowledge, upon my signature above that I do not require the written release of my eyeglass or contact lens prescription . I further acknowledge the intent of mandatory prescription release legislation. I understand I can receive a written prescription at any time upon written or oral request.