



Lisa K. Feulner, M.D., Ph.D.

Dear Patient:

Welcome to Advanced Eye Care. We are committed to providing you with the highest quality eye care.

As this is the first time we have had the pleasure of welcoming you to our full service eye health care practice, we would like to share with you a few things you may expect during your visit.

During your eye exam one of our team members will begin by asking you a number of questions, to include:

- The reason for your visit
- Your medical history (especially as it relates to your eyes) and your family's medical history
- The medications you are currently taking and any allergies or adverse drug reactions you may have experienced in the past.

Then, a member of our team will perform some preliminary tests to measure your vision and the general health of your eyes.

Upon completion of these tests, some drops will be placed in your eyes that will dilate your pupils. Your pupils are dilated so that we may more thoroughly examine your eyes. It generally requires 20 to 30 minutes for your pupils to become fully dilated. Please note that the administered drops will cause light sensitivity and may blur your near vision for approximately 4 – 6 hours.

If you are being seen by a member of our optometry staff for a **routine eye exam**, we will perform a simple test called a refraction. This is the part of the complete eye exam that helps the doctor determine your need for prescription glasses or contact lenses. **The cost of refraction IS included in your routine eye exam.**

If you are being seen for a **medical eye exam**, we may also need to perform a refraction for diagnostic purposes. Please note - **the cost of a refraction IS NOT included as part of the eye medical exam.** Although it is often a necessary part of the examination, most insurance companies will not cover this procedure if conducted during a medical eye exam. Please expect to pay a slight fee (\$ 25.00) in addition to your co-payment that will be collected on the day of your visit should a refraction be performed.

Please feel free to ask any staff member questions about your eye examination. Our goal is to provide you with a better understanding of the care you will be receiving at Advanced Eye Care today. We look forward to seeing you shortly!

Sincerely,

Lisa K. Feulner, M.D., Ph.D.

Patient Signature: _____



Lisa K. Feulner, M.D., Ph.D.

Dear Patient:

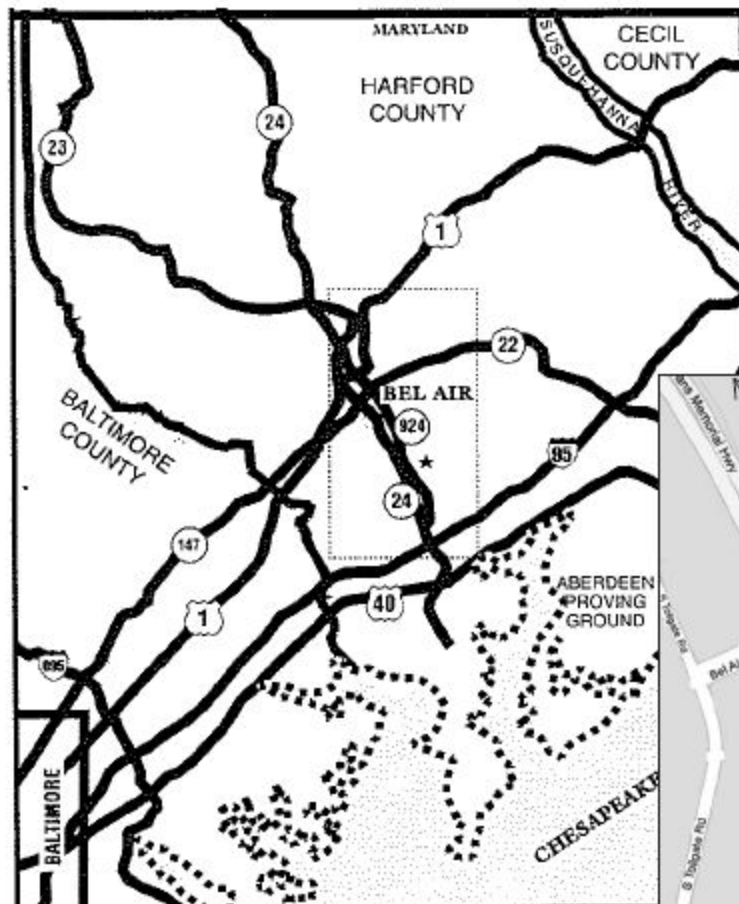
Enclosed is your patient information packet regarding your appointment with Advanced Eye Care. Please arrive **20 minutes prior** to your scheduled appointment time for registration. Be sure to complete this packet in its entirety and kindly bring the following items with you to your appointment:

- the completed packet
- insurance cards
- photo ID
- **full updated medication list**
- contact lenses and solutions
- all glasses including sunglasses
- copay and referrals

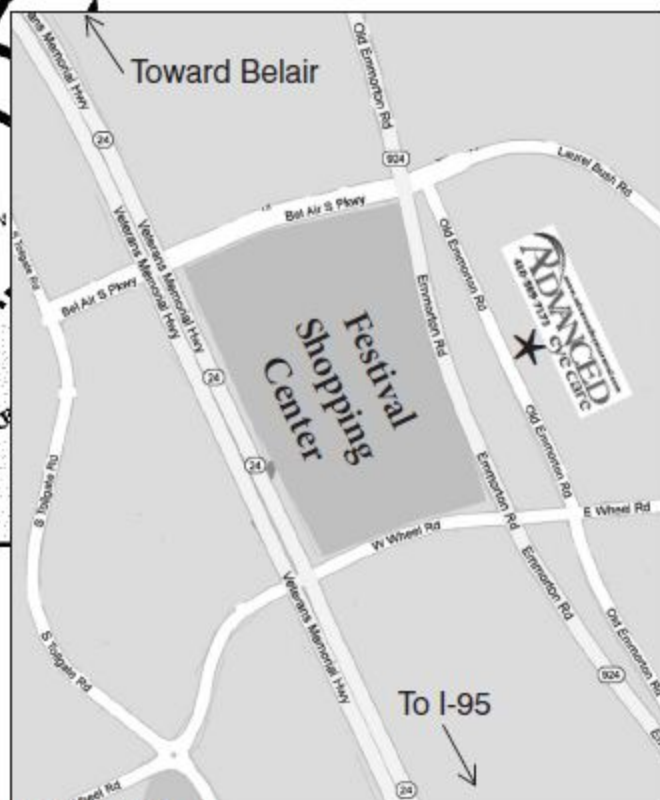
It may be necessary, for diagnostic purposes, to perform a **refraction** during your examination. A **refraction** is part of the complete eye exam that helps the doctor evaluate your cataract, macular degeneration, glaucoma, blurred or change in vision, etc. This may help determine whether or not you need further treatment. It also determines the prescription for your best spectacle correction. Although it is often a necessary part of the examination, most insurance companies do not cover this procedure. We require this \$25 fee to be collected on the day of your visit.

If you have any questions or you are unable to keep your appointment, please call 410-569-7173.

Thank you,
Advanced Eye Care



Regional Map



Detailed Map

From I-95:

Take I-95 to exit 77B (*Route 24 North*). Follow Route 24 North, approximately 3 miles, to Wheel Rd. Turn right on Wheel Road (*before Festival Shopping Center*) At the next light cross over Emmorton Road (*Route 924*). Make the immediate left onto Old Emmorton Commons. The office is located around the back.

From Route 1 Bypass:

Turn onto Route 24 South (*toward Harford Mall*). Proceed on Route 24 past Harford Mall, approximately 2.5 miles. Turn left onto Wheel Road (*after Festival Shopping Center*). At the next light cross over Emmorton Road (*Route 924*). Make the immediate left onto Old Emmorton Road. Make a right into Old Emmorton Commons. The office is located around the back.

Lisa K. Feulner, M.D., Ph.D

2227 Old Emmorton Road, Suite 114

Bel Air, MD 21015

410-569-7173 • Fax 410-569-7123

lkf@AdvancedEyeCareMD.com

www.AdvancedEyeCareMD.com

PATIENT INFORMATION

Patient's Legal Name: Last _____ First _____ MI _____
Address _____ City _____
State _____ Zip _____ Primary Care Physician _____
Optometrist _____
Referred by _____
 Yellow Book Verizon Yellow Pages Internet Insurance Newspaper Magazine
Home Phone _____ Work Phone _____
Cell Phone _____ Email address _____
Social Security Number _____ Birth Date _____ Age _____
 Single Married Divorced Widowed Separated Race _____ Male Female
Employer _____ Occupation _____
Name of Spouse or Parent/Guardian _____ Phone _____
Name & Phone Number of Emergency Contact _____

INSURANCE INFORMATION

MEDICAL

Primary _____ Policy# _____ Group # _____
Policyholder & Relationship to Patient _____ DOB _____
Secondary _____ Policy# _____ Group # _____
Policyholder & Relationship to Patient _____ DOB _____

VISION

Vision Plan _____ Policy# _____ Group # _____
Policyholder & Relationship to Patient _____ DOB _____

IF YOU HAVE A WORK RELATED INJURY, PLEASE BE ADVISED THAT YOUR MEDICAL INSURANCE CAN NOT BE BILLED. PLEASE SEE RECEPTIONIST FOR ADDITIONAL FORMS. ARE YOU HERE FOR A WORK RELATED INJURY? YES _____ NO _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to which I am entitled, for services rendered by Lisa K. Feulner, M.D., Ph.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby assume financial responsibility for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

I understand Lisa K. Feulner, M.D., Ph.D., P.A. reserves the right to pursue delinquent accounts via third party collection agencies or attorneys and that I am responsible for any collection fees incurred by Lisa K. Feulner, M.D., Ph.D., P.A.

I hereby attest that all information above is true.

Signature _____ Date _____

FINANCIAL & OPTICAL AGREEMENT POLICY

MEDICAL/GENERAL

1. A copy of your photo I.D. and insurance card(s) are required upon check-in.
2. Payment of copay, co-insurance and/or deductible is due at the time of service.
3. Referrals from your primary care physician are due at the time of service. If you do not have your referral, the appointment will need to be rescheduled.
4. A \$40 missed appointment fee will apply for appointments not canceled within 24 hours of the scheduled appointment date.
5. Should a refraction be required during a medical eye examination, we will require a \$25 fee in addition to your co-pay to be collected on the day of your visit. Although, a refraction is often a necessary part of a medical eye examination, most insurance companies will not cover this procedure.
6. We accept cash and credit cards (Care Credit, Visa, MasterCard and Discover).
7. We will accept personal checks with proper I.D. There is a \$35 fee for each returned check.
8. As a courtesy to you, we will file supplemental insurance claims when appropriate.
9. If you do not have insurance, total payment is due at the time of service.
10. Balance bill payments are due within 30 days of final payment by the insurance company.
11. Payment arrangements can be made at the time of service if the balance exceeds \$100.00.
12. There will be a \$25 fee to complete forms relating to disability, insurance, FMLA, and MVA forms. Please expect at least five (5) business days for completion of these forms.
13. Eye Exam fees are non-refundable.

OPTICAL SPECIFIC

1. Optical payments are required at the time of service.
2. There is a 20% restocking fee based on usual & customary cost on all returned optical products.
3. NO refunds will be considered after 90 days from the original purchase date.
4. All new and previous contact lens wearers will be charged an annual contact lens evaluation fee, which ranges from \$50 - \$105. ***This fee is in addition to the eye exam fee.***

If you have any questions regarding the financial policy or about your visit, please call 410-569-7173.

I have read and agree to the terms of this agreement. Regardless of my insurance status, I am ultimately responsible for the balance on my account. I understand that if for any reason my insurance company denies payment on either services or materials, I am responsible for payment in full. I authorize the release of any pertinent information in order for claims to be processed.

SIGNATURE OF PATIENT OR REPRESENTATIVE

PRINTED NAME

DATE

PRACTICE REPRESENTATIVE

THANK YOU FOR CHOOSING ADVANCED EYE CARE

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of ADVANCED EYE CARE'S Notice of Privacy Practices effective September 23, 2013.

How may we contact you for appointment reminders and notification of glasses/contact lens arrival?

Home answering machine Yes/No Voicemail Yes/No Email Yes/No Text Yes/No

Print Name: _____ Signature: _____ Date: _____

I am a parent or legal guardian of _____ (patient name). I have received a copy of ADVANCED EYE CARE'S Notice of Privacy Practices effective September 23, 2013.

Print Name: _____ Relationship to Patient: Parent Legal Guardian

Signature: _____ Date: _____

This consent allows ADVANCED EYE CARE to disclose your information to whoever is listed below. Please print the names and phone numbers of the individuals.

| | |
|----------------|--------------------|
| Spouse _____ | Phone Number _____ |
| Parents _____ | Phone Number _____ |
| Children _____ | Phone Number _____ |
| Other _____ | Phone Number _____ |

(Please specify relationship)

FOR OFFICE USE ONLY

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective September 23, 2013 given to individual on _____ (date)

In Person Mailing Email Other _____

Reason individual or parent/legal guardian did not sign this form:

Did not want to Did not respond after more than one attempt Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

In person conversation _____

Telephone contact _____

Mailing _____

Email _____

Other _____

Staff Name (please print): _____ Signature: _____

Title: _____ Date: _____

**NOTICE OF PRIVACY PRACTICES
SHORT FORM SUMMARY**

This Notice is Effective as of: September 23, 2013

This is only a summary of our Notice of Privacy Practices. Please review the full Notice following this summary to learn how we use and disclose medical information about you and your rights concerning these uses and disclosures.

How We Use and Disclose Your Information

We will obtain your written authorization for any uses and disclosures of protected health information “PHI” not described in the Notice of Privacy Practices.

Treatment, Payment, and Health Care Operations. We may use your PHI in order to provide your medical care; to bill for our services and to collect payment from you or your insurance company; and for the general operation of our business.

Marketing, Fundraising, and Sale of PHI. We will obtain your prior written authorization before sending you certain marketing communications. We may use or disclose your demographic information in order to contact you for our fundraising activities, but you have the right to opt out of such communications. We will not sell your health information without your prior written authorization.

We may use your PHI as otherwise authorized or required by law for such purposes as:

- public health reporting and oversight activities
- judicial, administrative, or law enforcement proceedings
- complying with workers’ compensation laws
- communicating with your family or caregivers

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment, that you should schedule an appointment, or we may need to change your appointment. If you are not home, we may leave this information in a telephone message or a message left with the person answering the phone.

You Have the Right to:

- Request certain restrictions on our use and disclosure of your PHI.
- Request communications from us by specific means or locations.
- Inspect and copy your medical record.
- Ask us to correct the information in your medical record.
- Receive an accounting of disclosures of your PHI by our practice.
- Be notified in the case of a breach of unsecured PHI.

CONTACT US

Contact our Privacy Officer with any questions, comments, or complaints or to exercise any of your rights to the PRACTICE ADMINISTRATOR 410.569.7173.



Lisa K. Feulner, M.D., Ph.D.

NOTICE OF PRIVACY PRACTICES

This Notice is Effective as of: September 23, 2013

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.

We understand the importance of privacy and confidentiality and are committed to taking the steps necessary to safeguard any medical or other individually identifiable health information that is created by or provided to us. The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires us to: (i) maintain the privacy of protected health information (“PHI”); (ii) provide notice of our legal duties and privacy practices with respect to protected health information; (iii) abide by the terms of our Notice of Privacy Practices currently in effect; and (iv) notify affected individuals following a breach of unsecured PHI. This Notice describes how we may use and disclose your PHI. It also outlines your rights and our legal obligations with respect to this PHI.

WHO WILL FOLLOW THIS NOTICE

This notice describes the practices of our employees and staff.

INFORMATION COLLECTED ABOUT YOU

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as:

- Your name, address, and phone number.
- Information relating to your medical history.
- Your insurance information and coverage.
- Information concerning your doctor, nurse, or other medical providers.
- Your spouses and employer information.

In addition, we will gather certain medical information about you and will create a medical record of the care provided to you. This information is stored in an electronic chart and in some cases, a paper chart. This medical record is the property of our ophthalmic practice, but the information in the medical record belongs to you.

Some information also may be provided to us by other individuals or organizations that are part of your “circle of care,” such as your primary care provider, a referring physician, your other doctors, your health plan, and your close friends or family members.

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU

The law permits us to use and disclose personal and identifiable health information about you for the following purposes:

Treatment. We may use your PHI in order to provide your medical care. For example, we may use your medical history, such as any presence or absence of diabetes, to assess the health of your eyes. We may disclose information to others who are involved in providing your care. For example, we may share your medical information with other health care providers who will perform services that we do not (such as your primary care physician or eye subspecialists); a pharmacist who needs your medical information to dispense a prescription to you; or a laboratory that performs a test we order for you.

Payment. We may use and disclose your PHI to bill for our services and to collect payment from you or your insurance company. For example, we may need to give a payer information about your current medical condition so that it will pay us for the eye examinations or other services that we have furnished you. We may also need to inform your payer of the treatment you are going to receive in order to obtain prior approval or to determine whether the service is covered.

Health Care Operations. We may use and disclose your PHI for the general operation of our business. For example, we sometimes arrange for auditors or other consultants to review our practices, evaluate our operations, and tell us how to improve our services. Or, for example, we may use and disclose your health information to review the quality of services provided to you

Required by Law. As required by law, we will use and disclose your PHI, but we will limit our use or disclosure to the relevant requirements of the law.

Public Health. We may disclose your PHI to a public health authority authorized to collect or receive PHI for the purpose of preventing or controlling disease, injury, or disability. We may also use and disclose your PHI in order to notify persons who may have been exposed to a disease or who are at risk of contracting or spreading a disease.

Abuse or Neglect. As required or authorized by law, we may disclose PHI to a public health authority or other government authority authorized by law to receive reports of child, elder, or dependent abuse or neglect or domestic violence.

Food and Drug Administration. We may disclose PHI to a person subject to the jurisdiction of the Food and Drug Administration for the following activities: to report adverse events, product defects or problems, or biological product deviations; to track products; to enable product recalls, repairs, or replacements; or to conduct post-marketing surveillance.

Serious Threat. Consistent with applicable law, we may disclose your PHI when necessary to prevent a serious threat to the health and safety of you or others.

Health Oversight Activities. We may disclose your PHI to health oversight agencies as authorized or required by law for health oversight activities such as audits, investigations, inspections, licensure or disciplinary actions, and civil, criminal, or administrative proceedings or actions.

Judicial and Administrative Proceedings. We may disclose your PHI in the course of administrative or judicial proceedings (a) to the extent expressly authorized by order of a court or administrative tribunal or (b) in response to a subpoena, discovery request, or other lawful process that is not accompanied by a court or administrative order if reasonable efforts have been made to (i) notify you of the request and you have not objected or your objections have been resolved by a court or administrative tribunal or (ii) secure a qualified protective order.

Law Enforcement. We may disclose your PHI as required by law to assist law enforcement to identify or locate a suspect, fugitive, material witness, or missing person, or for purposes of complying with a court order, warrant, or grand jury subpoena.

Coroners and Funeral Directors. We may disclose a patient's health information (1) to a coroner or medical examiner to identify a deceased person or determine the cause of death and (2) to funeral directors as necessary to carry out their duties.

Organ Donation. As authorized by law, we may disclose your PHI to organ procurement organizations, transplant centers, and eye or tissue banks.

Worker's Compensation. We may disclose your PHI as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or worker's compensation insurer.

Employers. We may disclose your PHI to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury.

Armed Forces. If you are a member of the Armed Forces, we may disclose your PHI for activities deemed necessary by military command authorities. We also may disclose health information about foreign military personnel to their appropriate foreign military authority.

Correctional Institutions. If you are an inmate, we may release your PHI to a correctional institution where you are incarcerated or to law enforcement officials in certain situations such as where the information is necessary for your treatment, health, or safety, or the health or safety of others.

National Security. We may disclose your PHI for national security and intelligence activities and for the provision of protective services to the President of the United States and other officials or foreign heads of state.

Business Associates. We sometimes work with outside individuals and businesses that help us operate our business successfully, such as by providing billing services. We may disclose your PHI to these business associates so that they can perform the tasks that we hire them to do. We have written contracts with our business associates that require them and their subcontractors to protect the confidentiality and security of your PHI.

Notification and Communication with Family. We may disclose your PHI to notify persons responsible for your care about your location, general condition, or death. We may also disclose your PHI to someone who is involved with your care or helps pay for your care. Generally, we will obtain your oral agreement before using or disclosing health information in this way. However, under certain circumstances, such as in an emergency situation, we may make these uses and disclosures without your agreement. If you are unable or unavailable to agree or object, we will use our best judgment in communicating with your family and others.

Disaster Relief. We may use and disclose PHI for disaster relief efforts.

Change of Ownership. In the event that this medical practice is sold or merged with another organization, your medical record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Research. In compliance with governing law, we may use or disclose certain information about your condition and treatment for research purposes where your written authorization is not required and an Institutional Review Board or a similar body referred to as a Privacy Board determines that your privacy interests will be adequately protected in the study. We may also use and disclose your PHI to prepare or analyze a research protocol and for other research purposes.

De-identified Information. We may create or distribute de-identified health information by removing all reference to individually identifiable information.

Marketing.

We will obtain your prior written authorization before communicating with you (except face-to-face) about products or services related to your treatment or alternative treatments or therapies offered by a third party if we will receive any payment by such third party for this communication. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity if you revoke that authorization.

We do not need your authorization to send you reminders or information about appointments, treatment, or medication that you are currently prescribed, even if we receive compensation from a third party for doing so, as long as the compensation only covers the costs reasonably related to making the communication.

We may communicate with you without your prior authorization:

- about government or government-sponsored public benefit programs such as Medicare or Medicaid;
- about promotional gifts of nominal value;
- and to encourage you to maintain a healthy lifestyle, get routine tests, or participate in a disease management program.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment or that you should schedule an appointment. If you are not home, we may leave this information in a telephone message or a message left with the person answering the phone.

Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information if you revoke that authorization.

Fundraising. We may use or disclose your demographic information in order to contact you for our fundraising activities. For example, we may use the dates that you received treatment, the department of service, your treating physician, outcome information, and health insurance status to identify individuals that may be interested in participating in fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed in this Notice and we will stop any further fundraising communications. Similarly, you should notify the Privacy Officer if you decide you want to start receiving these solicitations again.

Psychotherapy Notes. If we have received your psychotherapy notes, we will not use or disclose them without your prior written authorization except for a few exceptions as provided by law.

Immunization Records. We may disclose PHI, limited to proof of immunization, to a school about an individual who is a student or prospective student if the school is required by law to have such proof and we obtain the agreement of the parent or guardian of the unemancipated minor or, if the student is an adult or emancipated minor, that individual.

OTHER USES AND DISCLOSURES OF PERSONAL HEALTH INFORMATION

We are required to obtain written authorization from you for any uses and disclosures of PHI other than those described above. If you provide us with such permission, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your PHI for the reasons covered by your written authorization, except to the extent we have already relied on your original permission.

INDIVIDUAL RIGHTS

To exercise any of your rights listed below, please contact our Privacy Officer in writing at the address listed below and include the details necessary for us to consider your request.

Restriction Requests. You have the right to ask for restrictions on certain uses and disclosures of PHI, including disclosure made to persons assisting with your care or payment for your care. We will consider your requests and notify you of the outcome, but are not required to accept such requests. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

Restricted Disclosures to Health Plans. If you have paid for services “out of pocket” and in full, we will accommodate your request not to disclose PHI related solely to those services to a health plan, unless we must disclose the information for treatment or as required by law.

Specific Communications. You have the right to request that you receive communications containing your PHI from us by specific means or at specific locations. For example, you may ask that we only contact you at home or by email. We will comply with all reasonable requests.

Inspect and Copy. With limited exceptions, you have the right to inspect and copy medical, billing, and other records used to make decisions about you. We will provide copies in the form and format you request if it is readily producible. If not, we will provide you with an alternative form and format you find acceptable. If we maintain records electronically and you request copies in an electronic form and format that is not readily producible, we will provide copies in a readable electronic form and format that you agree to. We will send a copy to any other person you designate in writing. We may charge you a reasonable fee for the cost of copying and mailing. If we deny your request to access your child’s records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

Amend or Supplement. If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. When making a request for amendment, you must state the reason for making such request. Under certain circumstances, we may deny your request, such as when we do not have the information, the information was not created by us (unless the person or entity that created it is no longer available to make the amendment), you would not be permitted to inspect and copy the information, or the information is accurate and complete. If we deny your request you may submit a written statement of your disagreement with that decision. We may then prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

Accounting of Disclosures. You have the right to receive an accounting of disclosures of your PHI by our practice. We are not required to include in the list disclosures for your treatment, payment, our health care operations, and several other types of disclosures, such as those you authorize us to make, notifications and communications with family, and various government function and public health related disclosures. If you ask for this information from us more than once every twelve months, we may charge you a fee.

Breach Notification. In the case of a breach of unsecured PHI, you have the right to be notified, as provided by law. If you have given us a current email address, we may use it to communicate information related to the breach. In some circumstances our Business Associate may provide the notification. We may also provide notification by other methods as appropriate.

Copy of Notice. You have the right to a copy of this notice in paper form. You may ask us for a copy at any time.

CHANGES TO THIS NOTICE

We reserve the right to make changes to this notice at any time. We reserve the right to make the revised notice effective for all PHI we maintain and any we may receive in the future. In the event there is a material change to this Notice, the revised notice will be posted in our reception area. In addition, you may request a copy of the revised notice at any time.

COMPLAINTS

If you feel that your privacy protections have been violated by our office, you have the right to file a formal, written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights at 150 S. Independence Mall West, Suite 372, Public Ledger Building, Philadelphia, PA 19106-9111 or by email at OCRMail@hhs.gov.

YOU WILL NOT BE RETALIATED AGAINST OR PENALIZED BY US FOR FILING A COMPLAINT.

CONTACT US

Contact our Privacy Officer with any questions, comments, or complaints or to exercise any of your rights to the PRACTICE ADMINISTRATOR at 410-569-7173.

CURRENT & PAST MEDICAL HISTORY: Please check all that apply and indicate when diagnosed.

- | | | |
|--|---|---|
| <input type="checkbox"/> Acid Reflux/GERD | <input type="checkbox"/> DVT | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Edema | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> PVD |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Reynaud's Disease |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> HYPERTENSION (High Blood Pressure) | <input type="checkbox"/> Rheumatic Heart Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypercholesterolemia (High Cholesterol) | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cardiac Disease | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Congestive Heart Disease | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Dementia/Alzheimer's | | <input type="checkbox"/> Varicose Veins |
| | | <input type="checkbox"/> NONE |

OCULAR HISTORY: Please check all that apply and indicate when diagnosed and treated.

- | | | |
|---|---|---|
| <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> CATARACT SURGERY | <input type="checkbox"/> LASER SURGERY |
| <input type="checkbox"/> EYE TRAUMA | <input type="checkbox"/> LAZY EYE | <input type="checkbox"/> MACULAR DEGENERATION |
| <input type="checkbox"/> RETINAL DETACHMENT | <input type="checkbox"/> RETINAL SURGERY | <input type="checkbox"/> CORNEAL SURGERY |
| <input type="checkbox"/> OTHER OCULAR HISTORY | | |
-

PREVIOUS SURGICAL HISTORY: Please check all that apply.

- | | | |
|--|--|--|
| <input type="checkbox"/> Abdominal Surgery | <input type="checkbox"/> Cholecystectomy/Gallbladder | <input type="checkbox"/> Knee Replacement |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Cyst | <input type="checkbox"/> Mastectomy |
| <input type="checkbox"/> Ankle Surgery | <input type="checkbox"/> Ear Tubes | <input type="checkbox"/> Oral Surgery/Dental Procedure |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Foot Surgery | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Bladder Suspension | <input type="checkbox"/> Ganglion | <input type="checkbox"/> Stents |
| <input type="checkbox"/> Breast Surgery | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Cardiac Cauterization | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Vascular Surgery |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Vein Stripping |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Kidney Stone | <input type="checkbox"/> Wisdom Teeth |
| <input type="checkbox"/> C-Section | <input type="checkbox"/> Kidney Surgery | <input type="checkbox"/> NONE |

FAMILY HISTORY: Please check all that apply and indicate which family member.

- | | | |
|--|---|---|
| <input type="checkbox"/> Acid Reflux/GERD | <input type="checkbox"/> DVT | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Edema | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> PVD |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Reynaud's Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Heart Disease |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> HYPERTENSION (High Blood Pressure) | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypercholesterolemia (High Cholesterol) | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Cardiac Disease | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Congestive Heart Disease | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Dementia/Alzheimer's | <input type="checkbox"/> RETINAL DETACHMENT | <input type="checkbox"/> NONE |
| <input type="checkbox"/> GLAUCOMA | | <input type="checkbox"/> NA - ADOPTED |
| | | <input type="checkbox"/> MACULAR DEGENERATION |

PATIENT NAME: _____

REVIEW OF SYSTEMS: Please check all that apply.

Constitutional

- Chills
- Dizziness
- Fever
- Sweats
- Weight loss – intentional
- Weight loss – unintentional

Cardiovascular

- Chest pain/Heart Attack
- Fainting spells
- Heart palpitations
- Leg pain with exercise
- Leg/ankle/feet swelling

Endocrine

- Excessive thirst
- Frequent urination
- Intolerance to cold and heat

GU

- Frequent urination
- Urgency of urination
- Incontinence

Immunological

- Arthritic flare-ups
- Recurrent infections

Integument

- Bruise easily
- Dry skin
- Hair loss
- Hyperpigmentation
- Keloids (thick scars)

Lymphatic

- Bloating
- Swelling
- Pitting edema

GI

- Abdominal pain
- Constipation
- Diarrhea
- Heartburn
- Loss of appetite
- Nausea

Musculoskeletal

- Back pain
- Joint pain
- Leg cramps
- Muscle pain
- Stiffness

Neurological

- Numbness/tingling
- Seizures
- Tremors

Psychiatric

- Anxiety
- Binging
- Depression

Respiratory

- Difficulty breathing
- Shortness of breath
- Sleep apnea
- TB exposure

Head, Ears, Nose & Throat

- Difficulty hearing
- Difficulty swallowing
- Dry mouth
- Nose bleeds
- Ringing in ears

PATIENT NAME: _____

*****Newly required information by the U.S. Department of Health and Human Services. *****