

Anderson Hills  
Eye Care & Optical

**REGISTRATION FORM**

**PATIENT INFORMATION**

Mr.  Ms.  Mrs.

Sex: Male  Female

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: Single  Married  Separated  Divorced  Widowed

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employment Status (Circle One): Full-Time, Part-time, Not Employed, Self, Retired, Active Duty

Student Status (Circle One): Full-Time, Part-time

Family Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

Other Referral Source: Phone Book  Friend  Advertisement  explain \_\_\_\_\_

**Complete this section for either Spouse or Parent (if patient is a minor)**

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**IN CASE OF EMERGENCY CALL**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION**

Please complete the following for the subscriber of each insurance plan for which you have coverage.

Primary Insurance \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_  
Employer of Subscriber \_\_\_\_\_  
Address of Employer \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Secondary Insurance \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_  
Employer of Subscriber \_\_\_\_\_  
Address of Employer \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Third Insurance \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_  
Employer of Subscriber \_\_\_\_\_  
Address of Employer \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**Work Related Injury** (complete this section if today's exam is related to an injury obtained while performing work related duties)

Date of injury \_\_\_\_/\_\_\_\_/\_\_\_\_ Worker's Compensation Claim Number \_\_\_\_\_  
Employer at the time of injury \_\_\_\_\_  
Employer's phone number (\_\_\_\_) \_\_\_\_\_ Contact Person \_\_\_\_\_

# MEDICAL HISTORY

Name: \_\_\_\_\_

Birth Date \_\_\_\_\_

Family Doctor: \_\_\_\_\_

Date Last Eye Exam: \_\_\_\_\_

**Review of Systems:** Do you currently have any problems in the following areas:

	YES	NO		YES	NO
<b>FEVER</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>LUNGS:</b>		
<b>WEIGHT LOSS</b>	<input type="checkbox"/>	<input type="checkbox"/>	• Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
<b>EYES:</b>			• Cough	<input type="checkbox"/>	<input type="checkbox"/>
• Glasses	<input type="checkbox"/>	<input type="checkbox"/>	<b>STOMACH / INTESTINES:</b>		
• Contacts	<input type="checkbox"/>	<input type="checkbox"/>	• Pain	<input type="checkbox"/>	<input type="checkbox"/>
• Refractive Surgery	<input type="checkbox"/>	<input type="checkbox"/>	• Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
• Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	• Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
• Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<b>EAR / NOSE / THROAT:</b>		
• Halos	<input type="checkbox"/>	<input type="checkbox"/>	• Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
• Loss Peripheral Vision	<input type="checkbox"/>	<input type="checkbox"/>	• Allergies	<input type="checkbox"/>	<input type="checkbox"/>
• Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	• Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
• Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	• Deafness	<input type="checkbox"/>	<input type="checkbox"/>
• Burning	<input type="checkbox"/>	<input type="checkbox"/>	<b>ENDOCRINE:</b>		
• Itching	<input type="checkbox"/>	<input type="checkbox"/>	• Increased Thirst	<input type="checkbox"/>	<input type="checkbox"/>
• Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	• Increased Urination (frequency)	<input type="checkbox"/>	<input type="checkbox"/>
• Tearing	<input type="checkbox"/>	<input type="checkbox"/>	<b>NEURO:</b>		
• Redness	<input type="checkbox"/>	<input type="checkbox"/>	• Seizures	<input type="checkbox"/>	<input type="checkbox"/>
• Pain	<input type="checkbox"/>	<input type="checkbox"/>	• Headaches	<input type="checkbox"/>	<input type="checkbox"/>
• Discharge	<input type="checkbox"/>	<input type="checkbox"/>	• Migraines	<input type="checkbox"/>	<input type="checkbox"/>
• Flashes	<input type="checkbox"/>	<input type="checkbox"/>	<b>SKIN:</b>		
• Floaters	<input type="checkbox"/>	<input type="checkbox"/>	• Rash	<input type="checkbox"/>	<input type="checkbox"/>
• Protruding Eye(s)	<input type="checkbox"/>	<input type="checkbox"/>	• Eczema	<input type="checkbox"/>	<input type="checkbox"/>
• Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<b>JOINTS:</b>		
<b>HEART:</b>			• Pain	<input type="checkbox"/>	<input type="checkbox"/>
• Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	• Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
• Arrhythmia (irregular beat)	<input type="checkbox"/>	<input type="checkbox"/>			
• Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>			
• Chest Pain (Angina)	<input type="checkbox"/>	<input type="checkbox"/>			
• Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>			

( QUESTIONNAIRE CONTINUED ON OTHER SIDE )

**PAST MEDICAL HISTORY**

**EYE HISTORY**

**GENERAL HISTORY**

EYE MEDICATIONS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

GENERAL \_\_\_\_\_  
MEDICATIONS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PRIOR EYE DISEASES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PRIOR MEDICAL \_\_\_\_\_  
DISEASES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PRIOR EYE SURGERY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

GENERAL \_\_\_\_\_  
SURGERY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ALLERGIES: No   
Yes

LIST PLEASE \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

		YES	NO
Family History:	Ocular Family History		
	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>
	Amblyopia (Lazy Eye)	<input type="checkbox"/>	<input type="checkbox"/>
	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
	Retinitis Pigmentosa	<input type="checkbox"/>	<input type="checkbox"/>
	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
General Family History	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>

Social History: Alcohol Use  YES  NO  
Smoking  YES  NO  
If yes, how many glasses per day \_\_\_\_\_  
If yes, how many packs per day \_\_\_\_\_

Have you been in intimate contact with a person who has a sexually transmitted disease? YES  NO

Physicians Signature: \_\_\_\_\_ Date \_\_\_\_\_

**NOTICE OF USE OF PRIVATE HEALTH INFORMATION**

**Effective Date: April 14, 2003**

**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.**

**Our Pledge**

Anderson Hills Eye is an association of caring medical professionals dedicated to providing superior, comprehensive and cost effective eye care of the highest quality at our Centers of Excellence.

**Your Health Information**

An important part of our commitment to you is keeping your protected health information ("PHI") private in accordance with Federal and State Laws. We are required to provide you with a paper copy of this Notice of Privacy Practices ("Notice") should you desire which contains our privacy practices, our legal duties, and your rights concerning your PHI. We are also required to document your receipt of this notice after April 14, 2003.

**Who Sees and Shares my Health Information?**

*Treatment* Physicians, Nurses, Technicians, Assistants, and others involved in your medical care.

*Payment* Front Office Personnel, Managers, Billing Entry Personnel, Business Office Personnel, Collections Staff, and others involved in collecting payment for services rendered to you.

*Health Care Operations* Quality Assurance Audits, Reviews, Training Programs, Accreditation, Certification, Licensing, or Credentialing Activities among others to insure the quality of your health care.

**May I see My Health Information?**

You may see your health information, unless it is the private notes taken by a mental health provider or it is part of a legal case. Most of the time you can receive a copy if you ask. You may be charged a small amount for the copying costs.

If you think some information is wrong, you may ask in writing that it be changed or new information be added. You may ask that the changes or new information be sent to others who have received your health information from us. You may ask for a list of any of the places where health information may have been sent, unless it was sent for the treatment, payment, health care operations, or to make sure laws are being followed.

**What if my Health Information Needs to go Somewhere Else?**

You may be asked to sign a separate form, called an authorization form, allowing your health care information to go somewhere else if:

1. Your health care provider needs to send it to other places;
2. You want us to send it to another health care provider; or,
3. You want it sent to another person for you.

The authorization form tells us what, where and to whom the information must be sent. Your authorization is good until the date you put on the form. You may cancel or limit the amount of information sent at any time by letting us know in writing.

**Note:** If you are less than 18 years old, your parents or guardians will receive your private health information, unless by law you are able to consent for your own health care treatment. If you are, then your private health information will not be shared with parents or guardians unless you sign an authorization form. You may also ask to have your health information sent to a different person that is helping you with your health care.

**Could my Health Information be Released Without my Authorization?**

When private health information is released without Authorization, It is normally used to support **Treatment** or **Payment** or **Health Care Operations**. The release of health information for these purposes are not tracked or accountable to you, the patient (HIPAA rule 164.506). Any other release made without your authorization is tracked and is accountable. We always report:

1. Contagious diseases (as required by law), cancer;
2. Reactions and problems with medicine;

3. To the police when they are investigating a crime, when child or elder abuse may be happening, or when the court orders us to do so;
4. To the government to review how Anderson Hills Eye is performing;
5. Work related injuries to Workers Compensation;
6. To the Federal Government to when they are investigating something important to protect our country, the President and/or other government workers.
7. To employers relating to the medical surveillance of the workplace and work-related illnesses and injuries.

#### **How Can I find out if my Health Information has been Released Without my Authorization?**

To find out if your health information has been released without your authorization for purposes other than Treatment, Payment or Operations, you may call 513-388-4000 and ask for a Request for Accounting for Disclosures Form. Simply fill out the form and send it to:

HIPPA Contact Person  
Anderson Hills Eye  
7815 Beechmont Avenue  
Cincinnati, OH 45255

#### **How else can my Health Information be Used?**

The staff of Anderson Hills Eye may use your health information to contact you to provide appointment reminders, collection of payment, describing or recommending treatment alternatives, or providing information about health related benefits and services that may be of interest to you. With your permission, or in some emergencies, we may disclose your health information to your family, friends, or other people to aid in your treatment or the collection of payment. A disclosure of your health information may also be made if we determine it is reasonable necessary or in your best interests for such purposes as allowing a person acting on your behalf to receive prescriptions, prescription eyewear, medical supplies, test results etc.

#### **Questions or Complaints?**

If you have any questions about this notice, or you think that we have not protected your private health information and you wish to complain about it, please contact either of the following:

HIPPA Contact Person  
Anderson Hills Eye  
7815 Beechmont Avenue  
Cincinnati, OH 45255

**OR**

Office for Civil Rights  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Room 509F, HHH Building  
Washington, DC 20201-0004

or by calling the Office for Civil Rights at (800) 368-1019

#### **What will Happen to my Medical Records/Medical Care with if I do File a Complaint?**

Absolutely nothing. It is against the law for us to take any retaliatory or other negative action against you if you file a complaint.

#### **Can This Notice Change?**

Anderson Hills Eye reserves the right to update or change this Notice as Laws of our practice changes. If the Notice changes you will be notified as to how you can receive an updated copy.

# Anderson Hills Eye Care & Optical

## ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

1. By signing below, I acknowledge that I have been given the opportunity to read and receive a copy of Anderson Hills Eye's Notice of Privacy Practices ("Notice").

Date: \_\_\_\_\_.

Signature (Patient or Authorized Representative) \_\_\_\_\_.

Printed (Patient or Authorized Representative) \_\_\_\_\_.

### FOR OFFICE USE:

If you are unsuccessful in obtaining a signature from the patient or authorized representative explain circumstances below.

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature Staff Member

\_\_\_\_\_  
Date