

ENOCHS EYE CARE, PLLC
3575 Bridge Road, Suite 21, Suffolk, VA 23435
Phone: 757-638-2015 Fax: 757-638-2010

PATIENT INFORMATION: (PLEASE PRINT OR CIRCLE THE APPROPRIATE INFORMATION BELOW)

Last Name: _____ First: _____ MI: _____

Address: _____

Apt/Unit/Lot#: _____ City: _____ State: _____ Zip Code: _____

Patient Date of Birth: _____ SS#: _____ Marital Status: Married/Single/Widowed/Divorced

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Spouse: _____ Spouse DOB: _____ Spouse SSN: _____

Employment Status: Full Time/ Part Time/ Retired/ Disabled/ Student/ /Not Employed/ Other _____

Patient Employer: _____ Occupation: _____

Primary Care Doctor/Facility: _____ Office Phone #: (____) _____

INSURANCE INFORMATION: (PLEASE COMPLETE IN FULL)

1. Primary Insurance: _____ ID#: _____

Guarantor Name: _____ Home Phone: (____) _____

Guarantor SS#: _____ Gt. DOB: _____ Work Phone: (____) _____

Guarantor Place of Employment: _____

2. Secondary Insurance: _____ ID#: _____

RESPONSIBLE PARTY: (IF PATIENT IS A MINOR OR OTHER DEPENDENT)

Name: _____ Resp. Party Date of Birth: _____

Address: (if different than patient): _____
Street Address City State Zip

Primary Phone: _____ Secondary Phone: _____

Resp. Party: SSN: _____ Resp. Party Employer: _____

Patient/Resp. Party Signature: _____ **Date:** _____

1st Date Reviewed: _____ Pt. Initials: _____ Tech/Dr. Reviewed: _____ Initials: _____

MEDICAL HISTORY QUESTIONNAIRE

Patient: _____ Page 2

REASON FOR EXAMINATION: DATE OF LAST EYE EXAMINATION: _____

_____ Routine Eye Exam _____ Contact Lens Exam & Fitting _____ Medical Eye Problem

ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATIONS? YES / NO If yes, please list the medication:

MEDICATIONS: ARE YOU CURRENTLY TAKING ANY MEDICATIONS? YES / NO If yes, please list them:

Name of Medication Strength Dose Frequency

LIST OF MAJOR ILLNESSES: _____

LIST OF MAJOR SURGERIES: _____

SOCIAL HISTORY: Do you use tobacco products? _____ (If YES, what type/ how much) _____

Do you use alcohol products? _____ (If YES, what type/ how much) _____

Do you use illegal drugs? _____ (If YES, what type, how much) _____

Have you been exposed to, or do you have, or ever have had: HEPATITIS B/HIV/AIDS/OTHER: _____

FAMILY HISTORY: Has any member of your family had any of the following: (Please circle all that apply)

DIABETES, RETINAL DETACHMENT/DISEASE, GLAUCOMA, MACULAR DEGENERATION, CATARACTS,
CROSSED EYES, LAZY EYE, BLINDNESS, DEATH DUE TO ANESTHESIA

If so which relative?

PREVIOUS OPTICAL HISTORY:

PRESCRIPTION GLASSES: Do You Wear Prescription Glasses? YES/NO How many hours per day? ____

How long have you been wearing prescription glasses? _____ Do you have problems with glare? _____

Do you have problems with driving at night or night vision in general? _____

Computer Use: Do you frequently use computers? YES / NO How many days per week? _____

How many hours per day? _____ Do you get headaches or eye strain after viewing a screen? _____

CONTACT LENS: Do You Wear Contact Lenses? YES/NO DATE PRESCRIBED: _____

How long have you been wearing contact lenses? _____ Type of Lens: _____

REVIEW OF SYSTEMS

Have you ever had any problems in the areas listed below? If so, please check and circle all areas that apply.

	NO	YES	?		NO	YES	?
CONSTITUTIONAL				EARS, NOSE, MOUTH, THROAT			
Fever, Weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/ Hay fever/runny nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (SKIN)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL				Dry throat/mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches, Migraines, Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES				RESPIRATORY			
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma, Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	IMMUNOLOGIC: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Haze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CANCER: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR/CARDIOVASCULAR			
Starbursts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular disease, Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL			
Sandy/Gritty/Dry Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation, Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SKELETAL/JOINTS/MUSCLAR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain/Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain, Arthritis, Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infection of eyelids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Connective Tissue Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC / HEMATOLOGIC			
ENDOCRINE				Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FINANCIAL POLICY: Thank you for choosing Enochs Eye Care PLLC as your eye health care provider. Our office will file insurance claims as a courtesy to our patients, including Medicare, Virginia Medicaid, Anthem, Optima, CIGNA, UnitedHealth Care, and any other commercial plans that we participate with. Please remember that your insurance is a contract between you and your insurance company and any and all copays and deductibles are due at the time of treatment. All necessary referrals are ultimately the responsibility of the patient, as per your insurance guidelines. It is the responsibility of the patient to update Enochs Eye Care PLLC of any and all demographic and insurance changes at the time of service. Failure to do so will result in the patient being responsible for 100% of the services and products charged.

I agree that in return for the services provided to the patient by Enochs Eye Care PLLC, I will pay my account at the time services are rendered or will make financial arrangements satisfactory to Enochs Eye Care for payment. If an account is sent to a collection agency and/or attorney for collection, I agree to pay the collection expenses of 33.3% in addition to the amount due and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand that there is a \$35 fee for all returned checks. I understand that if my account is delinquent, I may be charged interest at the legal rate. I hereby authorize my insurance company to reimburse Enochs Eye Care PLLC directly. If copayments and or deductibles are designated by my insurance company or health plan, I agree to pay them to Enochs Eye Care PLLC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Patient Signature: _____ Date: _____

Responsible Party: _____ Date: _____

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version explaining what HIPAA is and how it protects you.

What this is all about: Specifically, these are rules and restrictions on who may see or be notified of your Protected Health Information, (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. (www.hhs.gov) We have adopted and implemented the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. Mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM, as of _____, and my subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.