George D. Shida, O.D.
Gemma Patel, O.D.
Optometric Physicians

EYE 1st VISION CENTER

901 Abernathy Road
Suite 100
Sandy Springs, GA 30328
(404) 252-1702
Fax: (404) 303-8843

Health History Date _____

Name _____ Age _____

Reason for today's exam _____

_____

Date of last exam _____ Name of eye doctor _____

Do you have a history of the following?

____Diabetes ____Thyroid Disease ____Arthritis
____High Blood Pressure ____Heart Disease ____Sinus/Allergy
____Stroke ____Lung Disease ____Other_____

Have you ever had any of the following conditions involving your eyes?

____Eye Surgery ____Sensitivity to Light ____Eye Infection
____Eye Injury ____Spots or Floaters ____Double Vision
____Severe Pain ____Eye Strain ____Poor Distance Vision
____Headaches ____Poor Near Vision ____Burning, Itching, Watering
____Cataracts ____Glaucoma ____Diabetic Retinopathy
____Blindness ____Lazy Eye ____Macular Degeneration

Do you have immediate family members treated for the following?

____Diabetes ____High Blood Pressure ____Heart / Lung Disease
____Cataract ____Glaucoma ____Macular Degeneration
____Other

Do you use cigarettes/tobacco? _____ Alcohol? _____ Other Substance?_____

Please list all medications and eye drops you are currently taking _____

Are you allergic to any medications? Please list _____
When do you wear your glasses?

____All the Time ____Reading/Near Work ____Work Safety
____Distance Only ____Computer Work ____Other _____

Have you ever worn contact lenses? ____ Yes ____ No
Are you interested in wearing contact lenses? ____ Yes ____ No
Are you interested in refractive surgery (LASIK)? ____ Yes ____ No
Do you work at a computer or video display terminal? ____ Yes ____ No

What hobbies or sports do you participate in? _____

_____

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Welcome

Name _____Today's Date ____/_____/___
First Middle Initial Last

Address: _____ Apt. _____ City_____ State_____ Zip_____

We require 2 separate phone numbers:

Home (___)___-_____ Wk (___)___-_____Cell (___)___-_____Alternative (___)___-_____

DOB_____/_____/____ SS#_____-____-_____ Email address_____@_____

Marital Status_____ Employer_____ How did you hear about us? _____

PLEASE CIRCLE ONE ON EACH LINE BELOW:

Communication Pref: Phone Email US Mail
Race: Latino African American Caucasian Asian American Indian Other
Ethnicity: Not Hispanic/Latino Hispanic/Latino Native Hawaiian/Other Pacific Island
Preferred Language: _____

Do you have vision insurance? _____ Ins. Co _____
Name of primary insured_____ Relationship to primary insured_____
ID#_____ Insured date of birth_____/_____/_____

Do you have medical insurance? _____Ins. Co _____
Name of primary insured_____ Relationship to primary insured_____
ID#_____ Group#_____ Insured date of birth_____/_____/_____

Authorization

I authorize Eye1st Vision Center to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Eye1st Vision Center insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____**/**_____**/**____ **Rev. 12/13**
Signature of patient (or parent if a minor) Date

"Thank you for choosing Eye 1st Vision Center for your eye care needs."

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NOTICE OF PRIVACY PRACTICES

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.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS
The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We may further use or disclose your health information without your permission if required by law:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- for disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- for uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
-for disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
-for disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- for disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- for uses and disclosures to prevent a serious threat to health or safety;
- for uses or disclosures for specialized government functions;
- for disclosures relating to worker's compensation program;
- for disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS
We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services that might help you.

OTHER USES AND DISCLOSURES
We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. If we ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization we cannot disclose health information. If you do sign, you may revoke it at any time. Revocations must be in writing to the office contact person named at the beginning of this Notice.

By sending a written request to the office contact person named at the beginning of this Notice you can:

-ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations.
-ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E-mail to your personal E-mail address. We will accommodate these requests if they are reasonable.
-ask to see or to get photocopies of your health information. You will be able to review or have a copy of your health information within 30 days of asking us.
-ask us to amend your health information if you think that it is incorrect or incomplete.
-get a list of the disclosures that we have made of your health information within the past six years and get additional paper copies of this Notice.

We reserve the right to change this notice at any time as allowed by law.

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Shida's Notice of Privacy Practices.

Patient Name:_____

Signature:_____ **Date:**_____