ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read and or received a copy of Magie Mabrey Hughes Eye Clinic, PA's dba Arkansas Retina Clinic Notice of Privacy Practices effective January 1, 2015.

Name (please print): _____
Signature: _____
Date: _____

I am a parent or legal guardian of _____ (patient name). I have read and or received a copy of Magie Mabrey Hughes Eye Clinic, PA's Notice of Privacy Practices effective January 1, 2015.

Name (please print): _____
Relationship to Patient: ☐ Parent ☐ Legal Guardian
Signature: _____
Date: _____

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): _____ Title: _____

Signature: _____ Date: _____

Arkansas Retina

Name:_____

_____

DOB:_____

Date:_____

Please Circle One

Race:

American Indian / Alaskan Native / Asian /

African American / Native Hawaiian / White

Ethnicity:

Hispanic or Latino / Non Hispanic or Latino

Preferred Language:_____

_____

Preferred Method of Contact – Please Circle One:

Phone:

_____

Mail:_____

_____

Email:_____

Preferred Pharmacy:_____

Pharmacy Location:_____

This season have you had a flu shot: Yes _____ No _____

Have you EVER had a pneumonia shot: Yes _____ No _____

MEDICAL AND SURGICAL DISEASES
OF THE RETINA, MACULA AND VITREOUS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after and examination, it's best if you make arrangements not to drive yourself. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

For patients receiving laser or intravitreal injection treatments, please let is be known that this also makes driving risky to yourself and the drivers around you. Your signature below states that your ophthalmologist has discussed these driving risks with you.

I hereby authorize Dr. and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition. Other treatments such as laser and/or intravitreal injections are necessary to treat my condition.

_____

Patient (or person authorized to sign for patient) Date

PATIENT INFORMATION

1. Patient Name_____ Date_____

2. Address_____
Street City State Zip

3. Date of Birth_____ Age_____ Male/Female_____
Social Security #_____

4. Telephone (Work) _____ Telephone (Home) _____
Cell_____

5. Occupation _____ Employer _____
Address/Phone_____
Please Circle: Single Married Widowed Divorced

6. Complete if under 18 years of age or student

Name of Father_____
Date of Birth_____ Social Security #_____
Employer/Address/Phone _____

Name of Mother_____
Date of Birth_____ Social Security #_____
Employer/Address/Phone _____

7. Name of Referring Physician_____
Name of Family Physician_____

8. Are you personally responsible for the payment of your fees? ☐ YES ☐NO
If no, who is?_____

9. Is this a worker's compensation injury? If yes, list employer, address and supervisor authorizing treatment. _____

_____

10. Is any part of your eye examination covered by insurance? ☐ YES ☐ NO

Primary Insurance_____

ID#_____ Group#_____

Subscriber's Name _____

Subscriber's Date of Birth_____ Relationship to Patient_____

Secondary Insurance_____

ID#_____ Group#_____

Subscriber's Name _____

Subscriber's Date of Birth_____ Relationship to Patient_____

11. Whom to notify in emergency? (nearest relative)

Name_____ Relationship_____Home Phone_____

Address_____Work Phone_____

Authorization to Release Information

I hereby authorize the above doctor/doctors to furnish the insured's insurance company all information which said insurance company may request concerning my present claim.

Assignment of Insurance Benefits

I hereby assign to the doctor all money to which I am entitled for expense relative to the services performed from time to time, but not to exceed my indebtedness to said doctor. I understand I am financially responsible to said doctor for charges.

_____ _____

Responsible Party's Signature Date

MEDICAL HISTORY QUESTIONNAIRE

Name_____ Date_____

Date of birth_____ Date of last eye exam_____

List any medications you currently take (prescription and over the counter):

_____

_____

Do you have allergies to any medications: ☐ YES ☐ NO

If YES, list the medications:

_____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):

_____

_____

_____

List any surgeries you have had (cataract, tonsillectomy, appendectomy):

_____

_____

Do you *currently* have any problems in the following areas? If "YES", please provide information.

	YES	NO	Explanation of Problem
EYES (Glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			

Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL/CONSTITUTIONAL			
Fever			
Weight Loss			
Other			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			
CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			

PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)			

FAMILY HISTORY M=mother F=father S=sibling GP=grandparent

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

CURRENT OCCUPATION_____

EDUCATION (HIGH SCHOOL, VOCATIONAL SCHOOL, COLLEGE DEGREE:

_____

MARITAL STATUS (MARRIED,DIVORCED,SINGLE,WIDOWED):_____

DO YOU DRIVE? ☐ YES ☐ NO

DO YOU HAVE VISUAL DIFFICULTY WHEN DRIVING? ☐ YES ☐NO

DO YOU HAVE PROBLEMS WITH NIGHT VISION? ☐ YES ☐NO

HAVE YOU EVER TRIED TO WEAR CONTACT LENSES? ☐YES ☐NO

DO YOU CURRENTLY WEAR CONTACT LENSES? ☐YES ☐NO

IF YES, HOW LONG HAVE YOU WORN CONTACT LENSES?_____

DO YOU CURRENTLY WEAR GLASSES? ☐ YES ☐NO

IF YES, HOW LONG HAVE YOU HAD THE CURRENT PRESCRIPTION?_____

DO YOU DRINK ALCOHOL? ☐YES ☐NO IF YES: occasional 1/day 2-3/day 4+/day

DO YOU SMOKE? ☐YES ☐NO IF YES: occasional 1/2pack/day 1pack/day 1+pack/day

HAVE YOU EVER HAD A BLOOD TRANSFUSION? ☐ YES ☐NO

HISTORY REVIEWED ☐ NO CHANGES ☐ADDITIONS AS NOTED ABOVE