PATIENT REGISTRATION/HEALTH HISTORY

Today's Date:

Last Name	First	Nick Name	Middle	Preferred Phone ☐ Cell ☐ Home ( ) -
Address	City	State	Zip	Work Phone ( ) -

Birthdate	Age	Sex M F	Occupation (If Student, Grade in School)	Soc. Sec. No. Of Patient - -
Name Of Primary Insured		Birthdate	Patient Relationship To Responsible Party: Self ___ Spouse ___ Child ___ Other ___	Soc. Sec. No. Of Primary Insured - -
Email:			How did you find out about our office?	

Vision History

When was your last complete eye exam? Month ___________ Year _________

Where? ____ May we contact them if previous eye history is needed? Yes / No

Do you wear glasses? Yes / No	If yes, how long?	Do you wear contacts? Yes / No	If yes, how long?

How do you use your current glasses? (Please Check)

____ rarely ____ driving only ____ sports only
____ all the time ____ over contacts ____ sunwear only
____ distance only ____ computer only ____ work/safety only
____ reading only ____ recreation only

How would you classify your current contacts? (Please Check)

Wearing schedule	Remove from eye	Type of contact lens
____ daily wear	____ daily	____ hard
____ extended wear	____ every ___ week(s)	____ hard (gas permeable)
____ recreation only	____ every ___ month(s)	____ soft (disposable)
	____ other	

Do you currently have or have you recently experienced any of the following? (Please Check)

____ blur at far
____ blur at near
____ blur at computer
____ change in vision
____ sudden loss central vision
____ sudden loss peripheral vision
light sensitivity:
____ daytime (sunlight)
____ nighttime (headlights)
____ halos around lights

____ double vision
____ night blindness
____ seeing flashing lights
____ seeing spots
____ eye injury
eye surgery:
____ LASIK/PRK/RK
____ cataract
____ retina
____ other

____ eyes red
____ eyes feel dry
____ eyes itchy
____ eye infection(s)
____ eyes water
____ eye pain
____ crossed eye
____ lazy eye
____ eye strain
____ work on computer

____ reading disorder
____ tracking disorder
____ learning disorder
____ failed school screening
____ hearing disorder
____ dyslexia

Family history of eye disease: (Please Check All Appropriate)

____ Glaucoma ____ Macular Degeneration ____ Disease of Retina ____ Disease of the Cornea

____ Other Please List: ____

Medical History

Name of family doctor ____ Date of last physical? Month ______ Year ______

May we contact them if previous medical history is needed? Yes / No Phone No. ______________________________

Please List all medications you are currently taking: ____

____

____

Do you have any history of allergies (including medication)? Please List: ______________________________________

Do you currently have or have you ever been diagnosed with any of the following? (Please Check)

Do you currently use cigarettes/tobacco? Yes / No Do you currently use alcohol? Yes / No Do you currently use other non-prescribed substances? Yes / No

____ arthritis/joint disease:
____ osteoarthritis
____ lupus erythematosus
____ crohn's
____ juvenille rheumatoid
____ adult rheumatoid
____ psoriatic
____ musculoskeletal disorder:
____ myasthenia
____ parkinson's
____ neurologic disorder:
____ multiple sclerosis
____ seizure disorder
____ pituitary disorder

____ vascular disorder:
____ anemia
____ high blood pressure
____ high cholesterol
____ atrial fibrillation
____ heart attack
____ carotid artery disease
____ stroke
____ transient ischemic attack
____ diabetes
____ respiratory disorder:
____ asthma
____ COPD
____ emphysema

____ other systemic disorder:
____ hyperthyroid
____ Grave's disease
____ hypothyroid
____ Hashimoto thyroid
____ liver disease
____ cirrhosis
____ hepatitis
____ kidney disease
____ cancer:
____ lymphoma
____ breast
____ prostate
____ lung

____ skin disorder:
____ eczema
____ melanoma
____ basal/squamous cell
____ frequent headaches
____ migraine
____ sinus problems
____ head injury
____ pregnancy (currently)
____ seasonal allergies
____ HIV (positive)

Columbine Vision Clinic HIPPA Form and Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPPA), is a federal program promulgated by the Department of Health and Human Services, creating national standards to protect all medical records and other individually identifiable information used or disclosed in any way by our office. The Act give you, the patient, significant new rights regarding your medical records and individually identifiable information, which combined are referred to as your protected health information (PHI).

As required by "HIPPA", we have prepared this explanation of our privacy practices regarding your protected health information. This notice describes how protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We may use or disclose with or without your authorization your protected health information for purposed of treatment, payment, and during our normal health care operations. Examples are as follows:

Treatment – your protected health information may be given to another health care provider for the purpose of co-managing any diagnosed condition found during either a routine or acute care office visit.
Payment – your protected health information may be given to a third party entity by means of mail, phone, or electronically, for the purpose of collecting reimbursement for services rendered, confirming insurance coverage, and utilization review.
Health Care Operations – your protected health information may be reviewed by employees of our office in order to perform their routine daily activities. In the event of a merger or acquisition of our practice your protected health information may be transferred to another covered entity.

We may contact you by mail, email (if provided by you) or phone regarding your care at our office. We may not provide your protected health information to any third party for marketing purposes without your prior written authorization.

We may disclose information to the Food and Drug Administration (FDA) for public health purposes related to the safety, quality, or effectiveness of FDA-regulated products, including adverse events, product defects or dangerous products.

Any other uses or disclosures of your personal information will be made only with your written authorization. You may revoke any authorization in writing and we are obligated to abide by that written request, except in the event that information was already released based upon a prior authorization.

You have certain rights with regards to your protected health information. You may exercise these rights at any time by presenting them in writing to our Privacy Officer.

You have the right to restrict disclosures of your protected health information from any person or entity identified by you in writing; including by not limited to, family members, insurance carriers, or other health care practitioners. We will abide by this request unless you remove it in writing.
You have the right to request to receive confidential communication of protected health information by alternative means or to any alternative location.
You have the right to inspect, copy, or amend your protected health information at any time. Under certain circumstances we have the right to deny this request.
You have the right to request a copy of any disclosures made by our office of your protected health information for any five year period beginning after April 2003.

If you feel we have not properly respected the privacy of your protected health information, you may file a complaint with our Privacy Officer or the Department of Health and Human Services, Office for Civil Rights. By signing below, you are acknowledging that you have read our Notice of Privacy Practices. This also serves as authorization for columbine Vision Clinic to communicate any protected health information necessary for treatment, payment, or health care operations as outlined above.

Other than myself, the following persons may access my medical or financial information.

Name____ Phone number____________________

Name____ Phone number____________________

For a minor child: Parent or Guardian:_____________________________ Phone number:_______________

Patient or Parent Signature: _____________________________________ Date: _________________

Would you like a copy of our Privacy Practices Policy? Yes No (Circle One)

**Please inform us in writing if you would like any changes made to this form in the future.