CLIFFSIDE EYE CENTER
PATIENT OCULAR & MEDICAL HISTORY FORM

Name:	**Date:**
Age:	**Medical Doctor:**
Diabetic? Yes No # of years:	**Previous Eye Doctor:**
Referred by:	**Last Eye Exam:**
□ **Friend** □ **Brochure** □ **Internet** □ **Insurance** □ **Doctor**	**E-mail address:**

☑ **Reason for this visit:** □ Yearly exam to have glasses / contacts checked □ Vision has changed □ Diabetic Evaluation
□ Cataract Evaluation □ Second Opinion □ LASIK Evaluation

☑ **Any eye symptoms you have had:**

□ Blurred Vision	□ Burning	□ Eye Fatigue
□ Dryness	□ Stinging	□ Light Sensitivity
□ Cataracts	□ Itching	□ Headaches
□ Spots/floaters / flashes	□ Tearing	□ Migraines
□ Reading Difficulty	□ Redness	□ Diabetes
□ Glare/Halos /	□ Tired Eyes	□ Poor Night Vision / Night driving difficulty
	□ Pressure	□ OTHER: ______________

LIST MEDICATIONS/PILLS:

LIST EYE DROPS:

DRUG ALLERGIES: □ **No** □ **Yes** **Please list:**

Pharmacy Name/Town

Past, Medical, Family and Ocular History

Medical History & System Review	**Ocular History**	
☑	***Self***	***Family***
□ High blood pressure	□ Cataracts	□
□ Heart Condition:	□ Glaucoma	□
□ Diabetes YES/ NO YEARS= __________	□ Macular Degeneration	□
□ Cancer	□ Dry Eyes	□
□ Arthritis	□ Amblyopia/Lazy Eye	□
□ Respiratory Disease	□ Retinal Disorders	□
□ Ear / Nose / Throat Problems:	□ Infections	□
□ Diabetes YES/ NO YEARS=	□ Eye Surgery	□
□ Circulation Problems:	□ Laser Treatment	□
□ Neurological Problems:	□ Other: ______________	
□ Allergies:		
□ Other: ______________		

Social History: Please indicate your use of the following:
Alcohol_____# of drinks per week Smoking_____# cigarettes per day_____yrs
Do you drive? □ Yes □ No Hobbies & special interests: ______________

What type of eyeglass lenses do you currently wear? □ Single Vision □ Bifocal □ Progressive
Are you satisfied with your current glasses? □ Yes □ No If no, explain ______________

What type of contact lenses do you wear? □ Soft □ Disposable □ Gas perm.

How many hours per day do you use a computer? □ 1-3 hrs □ 3-6 hrs □ 6+ hours

Questions: ______________

UPDATED: 1 2 3 4 5 6 7 8 9 10 11 12/20

PATIENT SIGNATURE ______________

MD SIGNATURE ______________

CLIFFSIDE EYE CENTER
RICHARD LEVINE, MD

HIPPA AND PROTECTECTED HEALTH INFORMATION (PHI)

The Health privacy. Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect Health There are rules and restrictions on who may see or be notified of your Protected balance Information these needs (PHI). with our HIPPA provides certain rights and protections to you as the patient. We goal of providing you with quality professional service and care.

The used Notice and of Privacy Practices describes how Protected Health Information about you may be view the policy disclosed and how you can get access to this information. For more information and to www.hhs.gov. in its entirety, visit the U.S. Department and Human Services webpage information Cliffside Eye Center, LLC is required by law to protect the privacy of health appropriately. that may reveal your identity. Patient's information will be kept confidential and handled laboratories, pharmacies, This specifically includes the sharing of information with other health care providers, care. Protected and health insurance payers as is necessary and appropriate for your Health Information is information about you, including demographic information, that present may identify you as well as genetic information, and information that relates to your past, or future physical or mental health or condition and related health care services.

Keeping our patient's information private is important to us, and by default we will disclose information related to the patient's medical conditions only to the patient or legal guardian. Please let us know if you would like to authorize Cliffside Eye Center and Richard Levine, M.D. to discuss your medical care with:

______________________	______________________	______________________
Contact Name/Emergency Contact	**Relationship to Patient**	**Contact Phone Number**

By signing below, I certify that I have received and understand the Notice of Privacy Practices and consent to the use of my PHI as stated.

____
PRINT NAME OF PATIENT

______________________ ______________________
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

Cliffside Eye Center
Authorization for Service(s)

This signed document serves as a general authorization for the following:

I am aware that I am responsible for any fees not covered by my insurance, i.e.: insurance copay or co-insurance, deductible and/or refraction fee when applicable.

Self-Pay I understand that I am fully responsible for all fees associated with services rendered.

Insurance Authorization
I have provided Cliffside Eye Center with a copy of my current insurance coverage. I authorize them to submit claims for services rendered to my carrier. Additionally, I authorize the release of my medical records to my carrier as indicated to process my claims for payment.

Referrals
I understand that it is my responsibility to determine if a referral is needed under my insurance plan. The referral must be obtained from my primary care physician prior to my visit with Cliffside Eye Center. The undersigned fully understands that he/she is responsible for payment in full if they do not have a referral at the time service(s) are rendered.

____ ____________________

Patient or Guardian's Signature **DATE**