WELCOME TO OUR OFFICE

Date_____

Patient's Name (Please Print)_____

M or F_____ Birth Date_____ Age_____ Marital Status_____

Home Phone_____ Cell Phone_____Work Phone_____

Email Address_____

If Child, Parent/Legal Guardian's Name_____

StreetAddress_____City_____

State_____Zip Code_____Emergency Contact_____Phone_____

Employer_____Occupation_____

Health Insurance Carrier(s)_____Vision Insurance Carrier(s)_____

Subscriber's Name (Name of Policy Holder)_____

Birthdate of Policy Holder_____SS# of Policy Holder_____

Interests/Hobbies/Sports:_____

*Who may we thank for referring you to us?/ How did you hear about us?*_____

Dr. Sharon Adhami may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____Date_____

Signature of Patient, Parent, Guardian, or Personal Representative

I understand that I am financially responsible for all charges whether or not they are covered by insurance. I understand that if collection action should become necessary for recovery of monies due under this contract, I agree to pay any/all collection costs and attorney fees.

_____ Date_____

Signature of Patient or Legal Representative

EYE HEALTH HISTORY

Last Eye Care Physician_____
Date of last visit _____
Date of last eye exam _____
Do you wear glasses? ☐Yes ☐No
☐ All the time ☐ Occasionally
☐ Reading ☐ Driving ☐ TV
Do you wear contacts? ☐Yes ☐No
Do you sleep in your contacts? ☐Yes ☐No
Brand _____ Hours/Day _____
Prescription, if known: _____
Describe any problems you have with your contacts:
_____
_____
_____
_____

Circle " Yes" or " No" to indicate if you have had any of the following:

Bloodshot Eyes	Yes No	Eye Disease	Yes No
Blurred Vision- Distant	Yes No	Floaters or Spots	Yes No
Blurred Vision- Near	Yes No	Glaucoma	Yes No
Blurred Vision – Mid Range	Yes No	Headaches	Yes No
Burning Eyes	Yes No	Itching Eyes	Yes No
Cataracts	Yes No	Light Sensitivity	Yes No
Color Vision, Poor	Yes No	Loss of Vision	Yes No
Cobwebs/Curtain in Vision	Yes No	Migraine Headaches	Yes No
Crossed Eyes	Yes No	Night Vision, Poor	Yes No
Discharge from Eyes	Yes No	Red Eyes	Yes No
Dizzy Spells	Yes No	Retinal Detachment	Yes No
Double Vision	Yes No	Seeing Halos	Yes No
Dry Eyes	Yes No	Seeing Flashes	Yes No
Eye Infection	Yes No	Temporary Loss of Vision	Yes No
Eye Injury	Yes No	Twitching Eyelids	Yes No
Eye Strain	Yes No	Vision Poor	Yes No
Fainting spells, Blackouts	Yes No	Watering Eyes	Yes No

HEALTH HISTORY

Physician's Name _____ Date of last visit_____

Circle "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself	**Family Member**		**Yourself**	**Family Members**
AIDS/HIV	Yes No	Yes No	High Blood Pressure	Yes No	Yes No
Arthritis	Yes No	Yes No	Iritis/Uveitis	Yes No	Yes No
Artificial Heart Valve	Yes No	Yes No	Kidney Disease	Yes No	Yes No
Artificial Joints	Yes No	Yes No	Lazy Eye	Yes No	Yes No
Asthma	Yes No	Yes No	Lupus	Yes No	Yes No
Bleeding	Yes No	Yes No	Macular Degeneration	Yes No	Yes No
Cancer	Yes No	Yes No	Migraine Headaches	Yes No	Yes No
Cataracts	Yes No	Yes No	Poor Color Vision	Yes No	Yes No
Chemical Dependency	Yes No	Yes No	Retinal Disease	Yes No	Yes No
Depression/Anxiety	Yes No	Yes No	Rheumatic Fever	Yes No	Yes No
Diabetes	Yes No	Yes No	Shingles	Yes No	Yes No
Drug Sensitivity	Yes No	Yes No	Skin Conditions	Yes No	Yes No
Emphysema	Yes No	Yes No	Stroke	Yes No	Yes No
Epilepsy	Yes No	Yes No	Thyroid Conditions	Yes No	Yes No
Eye Surgery	Yes No	Yes No	Tuberculosis	Yes No	Yes No
Glaucoma	Yes No	Yes No	Turned Eye	Yes No	Yes No
Hay Fever	Yes No	Yes No	*Other Conditions:* _____		
Heart Condition	Yes No	Yes No	Are you pregnant?_____	Number of children_____	
Hepatitis (Type ____)	Yes No	Yes No	Tobacco use _____	Alcohol use _____	

MEDICATIONS/ALLERGIES

Medications:_____
_____
_____
_____
_____

Drug Allergies:_____
_____
_____

Pharmacy Name:_____Phone: ( )_____

Photographic / Media Consent

I give consent to Sharon Adhami, OD to take photographs and/or videos to display on social media tools which includes but is not limited to her Facebook and Instagram page. I understand that these images and/or videos will not be used for any other commercial purposes. I hereby hold harmless and release and forever discharge Sharon Adhami, OD from all claims, demands, and causes of action, which I have or may have by reason of this authorization.

_____ Date_____

Signature of Patient or Legal Representative

HIPAA Privacy Notice Consent

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. This Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). (Amended September 23, 2013)

This Consent was signed by:

_____

Patient or Guardian

_____ _____

Relationship to Patient (if other than patient) Date

UNENCRYPTED EMAIL WAIVER FORM

- **When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the internet. In addition, once the email is received by you, someone may be able to access your email account and read it.**
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA Act, the federal government provided guidance on email and HIPAA.
- The information is available in a PDF (page 5634) on the U.S. Department of Health and Human Services website – http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

PLEASE CHOOSE ONE OF THE FOLLOWING OPTIONS:

☐ OPTION 1 – **ALLOW** UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to Dr. Sharon Adhami to send me personal health information (ex: spectacle and contact lens prescriptions, etc) via unencrypted email when I request it to be sent.

_____
Printed Name

_____
Signature (parent or guardian if patient is a minor)

_____
Date

_____
Please print email address

☐ OPTION 2 – **DO NOT ALLOW** UNENCRYPTED EMAIL

I do not wish to receive personal health information via email, and I understand that any information wanted must be received by phone call or by personally coming in to the office to pick up paperwork.

_____
Printed Name

_____
Signature (parent or guardian if patient is a minor)

_____
Date