VISION SOURCE

Advanced Family Eyecare

Joana C. Pantoja, O.D.

Samuel C. Oliphant, O.D., F.A.A.O.

14000 Quailbrook Dr. Oklahoma City, OK 73134

(405) 751-7727 Fax (405) 755-1875

Please print in blue or black ink. Chart # _____

Patient Name: _____ **Preferred Name:** _____ **Age:** _____ **Date:** _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Email address: _____ Date of Birth: _____ Gender: ❑ M ❑ F SSN: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Legally Separated ❑ Widowed

Spouse's Name: _____ Phone Number: _____

Employer: _____ Position: _____

Race: ❑ White ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic ❑ Native Hawaiian/ other Pacific Island

Ethnicity: ❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑ Native Hawaiian/other Pacific Island

Preferred Language: ❑ English ❑ Spanish

Who may we thank for referring you to our practice? _____

May we use your name in thanking them? ❑ Yes ❑ No

Reason for today's visit: _____

Do you have any specific questions for your doctor today? _____

Are you planning on new eyeglasses today? ❑ Yes ❑ No ❑ Maybe Are you planning on purchasing contacts? ❑ Yes ❑ No

If not a contact lens wearer, are you interested in trying contacts today? ❑ Yes ❑ No ❑ Maybe

Are you interested in learning more about laser vision correction? ❑ Yes ❑ No

---

Additional Employment/Education Information (if applicable)

Employer: _____ Position: _____

If student, what is the major course of study? _____

How many hours daily are spent…

At a desk_____ Studying/reading_____

Working at near distance _____ On a computer_____

Visual History:

Have you had a previous vision evaluation? ❑ Yes ❑ No

If yes, doctor's name and date of evaluation _____

Reason for evaluation _____

Were any additional test treatments or therapies recommended concerning your vision? ❑ Yes ❑ No

If yes, what? _____

Did you undergo these treatments? ❑ Yes ❑ No

If yes, results: _____

Do you currently wear glasses or contact lenses? ❑ Yes ❑ No - If yes please select:

❑ Full-time ❑ Part-time distance ❑ Part-time near ❑ Contact Lenses

Glasses currently worn: ❑ Single Vision ❑ Bifocals ❑ Progressive ❑ Trifocals

How old were you when glasses were first prescribed? _____

Do you wear sunglasses? ❑ Yes ❑ No Are your sunglasses your most recent prescription? ❑ Yes ❑ No

Do you have any hobbies or jobs that require special glasses or contacts? _____

Social History:

Use of Alcohol: ❑ None ❑ Social use only ❑ 1-2 drinks daily ❑ Above average use ❑ Alcohol dependence

Use of Tobacco: ❑ None ❑ Former Smoker ❑ Light Smoker ❑ Average Smoker ❑ Heavy Smoker

Use of Narcotic: ❑ None or Type & frequency: _____

Sexually Transmitted Disease: ❑ Yes ❑ No If yes, name kind of STD _____ HIV Positive? ❑ Yes ❑ No

---

Family Members (please list):

Name/Relationship to you	Age	Last Eye Exam	Name/Relationship to you	Age	Last Eye Exam

Current Medications (please list):

1. _____ for _____ 6. _____ for _____
2. _____ for _____ 7. _____ for _____
3. _____ for _____ 8. _____ for _____
4. _____ for _____ 9. _____ for _____
5. _____ for _____ 10. _____ for _____

Drug Allergies ❑ Yes ❑ No Please list: _____

Ocular History

Please list all ocular surgeries:

Procedure: _____ Year: _____ Eye: R / L Doctor: _____

Procedure: _____ Year: _____ Eye: R / L Doctor: _____

Procedure: _____ Year: _____ Eye: R / L Doctor: _____

Medical History

Indicate any personal history below: (check all that apply)

Cardiovascular:
❑ Congestive Heart Failure
❑ Elevated Cholesterol
❑ High Blood Pressure
❑ Stroke

Endocrine:
❑ Diabetes
❑ Gout
❑ Thyroid (High or Low)
❑ Renal Disease (Kidney)

Gastrointestinal:
❑ Cancer: Colon, Liver
❑ Colitis
❑ Hepatitis
❑ Inflammatory Bowel Disease
❑ GERD (Acid Reflux)

Integumentary:
❑ Acne Rosacea
❑ Lupus
❑ Psoriasis

Hematologic/Lymphatic:
❑ Leukemia
❑ Sickle Cell Disease
❑ Temporal Arteritis
❑ Lymphatic Disorder

Immunologic:
❑ AIDS
❑ Sarcoidosis
❑ Sjogren's Syndrome
❑ Syphilis
❑ Tuberculosis

Musculoskeletal:
❑ Arthritis
❑ Rheumatoid Arthritis

Neurological:
❑ Bell's Palsy
❑ Brain Tumor
❑ Multiple Sclerosis
❑ Parkinson's Disease
❑ Seizures
❑ Alzheimer's

Psychiatric:
❑ Bipolar Disorder
❑ Depression
❑ Learning Disability
❑ Schizophrenia
❑ Anxiety Disorder

Genitourinary:
❑ Menopause
❑ Prostate Cancer
❑ Cervical Cancer
❑ Breast Cancer

Head/ENT/Dental:
❑ Chronic Cough
❑ Migraines
❑ Sinusitis
❑ Dizziness

Respiratory:
❑ Asthma
❑ COPD
❑ Emphysema
❑ Lung Disorder
❑ Lung Cancer

Family History

Condition	*Relationship to Patient*	*Condition*	*Relationship to patient*
❑ Amblyopia/Lazy Eye	_____	❑ Cancer	_____
❑ Blindness	_____	❑ Diabetes	_____
❑ Cataracts	_____	❑ Heart Disease	_____
❑ Glaucoma	_____	❑ Stroke	_____
❑ Retinal Detachment	_____	❑ Thyroid Disease	_____
❑ Macular Degeneration	_____	❑ Other	_____

Traumatic Brain Injury History:

Date of injury/accident: _____

Type of injury/accident:

❑ Motor vehicle
❑ Fall
❑ Blow to head
❑ Sports injury
❑ Industrial accident
❑ Medication related
❑ Drug abuse
❑ Carbon dioxide
❑ Drowning
❑ Cord around neck
❑ Stroke
❑ Aneurysm
❑ Hemorrhage
❑ Poison or toxic substance

❑ Other: _____

What part of the head was affected? (Check all that apply)

❑ Forehead ❑ Right side ❑ Left side ❑ Back of head ❑ Top of head ❑ Face

Was the injury OPEN HEAD (bleeding) or CLOSED HEAD (non-bleeding)? Check one: ❑ open ❑ closed

Was there a loss of consciousness ❑ Yes ❑ No If yes, for how long? _____

Were you in a coma? ❑ Yes ❑ No If yes, for how long? _____

Symptoms immediately following injury:

❑ Double vision
❑ Headache
❑ Dizziness
❑ Vomiting
❑ Flashes of light
❑ Disorientation
❑ Loss of balance
❑ Memory loss
❑ Restricted motion
❑ Pain in/around eyes
❑ Neck pain/whiplash

❑ Other: _____

Initial Treatment:

When did you first see a doctor regarding your accident/injury? _____
Where were you seen? _____ Were you hospitalized? ❑ Yes ❑ No If yes, for how long? _____
Name of Doctor: _____ Specialty: _____
What were you and your family told? _____
What did the initial treatments consist of? _____
What prognosis/recommendations were you given? _____
Were you given any medications? ❑ Yes ❑ No If yes, list medications _____
_____

Lifestyle:

Do you feel your vision interferes with activities of daily living? ❑ Yes ❑ No
If yes, please explain (please include effects involving home, work, hobbies, social relationships and personal relationships):
_____
_____
_____
What other changes/limitations in your daily life do you attribute to your accident/injury? _____
_____
_____
What do you hope a Visual Rehabilitation Program can do for you? _____
_____
_____

Primary Care Physician:

Name: _____ Phone: _____ Date of Last Physical Exam: _____

Subsequent Care:

What types of professional care have you received or are you currently receiving?

Physician – Name: _____ Date: _____

Results/recommendations: _____

Neurologist – Name: _____ Date: _____

Results/recommendations: _____

Neuropsychologist – Name: _____ Date: _____

Results/recommendations: _____

Physical Therapist – Name: _____ Date: _____

Results/recommendations: _____

Speech/Language Therapist – Name: _____ Date: _____

Results/recommendations: _____

Psychologist/Psychiatrist – Name: _____ Date: _____

Results/recommendations: _____

Occupational Therapist – Name: _____ Date: _____

Results/recommendations: _____

Other – Name: _____ Date: _____

Results/recommendations: _____

Payment Policy

1. Payment: Payment is expected at the time services are received.

2. Credit: Our office accepts Visa, MasterCard, American Express, Discover, and Care Credit

3. Insurance: We are not participating providers for any insurance companies. Therefore, payment is required at the time of service, and we will provide the necessary paperwork for you to file your own insurance claim if you choose to do so. Your insurance company will reimburse you directly for the portion they are contracted to pay, *which may not be the full amount of the examination.*

Signature: _____ Date: _____

Do you CURRENTLY experience any of the following (please check):

	Yes	No	Prior to injury?
Eyes Ache			
Eyes pull or drag			
Difficulty moving or turning eye (s)			
Pain with movement of eyes			
Eyes twitch			
Pain in or around eyes			
Eye redness			
Burning eyes			
Watery eyes			
Itchy eyes			
Brightness is bothersome			
Motion sickness/car sickness			
Headaches			
Blurred vision			
Double vision			
One eye turns in, out, up or down			
Movement of objects in the environment is bothersome			
Fluorescent light is bothersome			
Patterned wallpaper or carpets are bothersome			
Head moves when reading			
Lose place often when reading			
Words jump or move when reading			
Short attention span for reading or writing			
Skip words frequently when reading			
Discomfort when reading			
Loss of interest/concentration doing close work			
Orient writing/drawing poorly on page			
Head tilts during desk work			
Holds book too close			
Avoid reading or writing			
Difficulty with peripheral vision			
Objects jump in and out of field view			
Reduced depth perception			
Tunnel vision or loss of visual field			
Flashes of light			
Difficulty with dressing			
Difficulty with bathing/personal hygiene			
Difficulty following a series of directions			
Difficulty using both sides of the body together			
Dislikes heights			
Awkward, poor balance			
Dizziness			
Confusion/disorientation			
Get lost often			
Bothered by noises			
Bothered by touch			
Difficulty remembering things heard			
Difficulty remembering things seen			
Difficulty remembering names of objects			
Difficulty remembering people's names			
Difficulty remembering formerly familiar people or objects			
Difficulty performing tasks formerly easy/routine			
Difficulty with time management			
Difficulty with numbers			

Advanced Family Eyecare

Vision Source !
14000 Quailbrook Drive
Oklahoma City, OK 73134
Office (405) 751-7727
Fax (405) 755-1875
Web: www.afeyecare.com

THIS NOTICE DESCRIBED HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
(Revised 7-2013)

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

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 issues. 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 medication and sending them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Example of how we use or disclose your health information for payment purposes are: asking you about you health or vision care plan, or other source of payment; preparing and sending bills or claims; and collecting unpaid balances (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 routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, (we will) (we usually will not) ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, that law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state of 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 notice to and from the Federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims of suspected abuse, neglect, of domestic violence,
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audit by Medicare or Medicaid; for investigation of possible violations of health care laws;
- Disclosures for judicial and administrative proceeding, such as in response to subpoenas or orders of courts or administrative agencies;
- 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;
- 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;

- Uses or disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized government functions such as for the protection of the President or high ranking government officials; for lawful national intelligence activities; for military purpose; or for the evaluation and health of members of the foreign service;
- Disclosure of de-identified information; unidentified
- Disclosure relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- 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 available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/ or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DICLOSURES

We will not make any other uses or disclosures of you health information unless you sign a written "authorization form". The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person at the beginning of this notice.

We will not use or disclose any protected health information for marketing purposes or disclosures that constitute a sale of protected health information without your consent. Additionally, any other uses and disclosures not described in this notice will be made only with your authorization.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purpose of treatment (except emergency treatment), and payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.
- 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, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this notice.
- Ask to see or to get photocopies of your health information. By law, these are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off- site). You may

have to pay for photocopies in advance. If we deny your request we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have a 30 day extension of time for us to give you access or photocopies of your health information. Send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this Notice.

- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree we will amend the information within 60 days of your request. We will send the corrected information to persons we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position that we will include with your health information along with any rebuttal statement. We will send this with your health information whenever a permitted disclosure is requested/ needed. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. IF you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax, or E-mail shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want).By law, the list will not include: disclosure for purposes of treatment payment or health care operations; disclosures for authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it. By law we can have a 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E- mail shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. Does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax, or E-mail shown at the beginning of the Notice.
- You may restrict certain disclosures of protected health information to a health plan when you pay out of pocket in full for the health care item or service.
- In the event that there is a breach of unsecured protected health information, you will be notified by our office within 30 days of the breach.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that may generate in the future. If we change our Notice of Privacy Practice, we will post the new notice in our office, have copies available in our office, and post it on our Website.

COMPLAINTS

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. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax, or E-mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Advanced Family Eye Care Your *Vision Source!* Notice of Privacy Practices.

Patient Name: _____

Signature:_____

Date: _____

Authorization for Release of Information

I hereby request the disclosure of information from my record.

Patient Name: _____
Address: _____
City/State/Zip:_____/_____/_____
Phone: (_____)_____ DOB: ____/____/_____

The information is to be released **TO/FROM**:

Name/Agency: _____
Address: _____
City/State/Zip:_____/_____/_____
Phone: (_____)_____
Fax: (_____)_____
E-mail: _____
Contact Person(s): _____

The information is to be released by mail, phone, email, or fax **TO/FROM**:

Advanced Family Eyecare
14000 Quailbrook Dr.
Oklahoma City, OK 73134
(405) 751-7727/ fax (405) 755-1875

The information to be released is as follows:

❑ Any information contained in the patient's record

❑ Only information related to the patient's educational success (Specify)

_____
_____
_____

- I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date authorized.
- I understand that the recipient of the disclosed protected health information may not have any legal obligation to maintain the further confidentiality of the protected health information.
- We cannot refuse to treat you if you choose not to sign this form.

Signature: _____ Date: _____
(Patient, Parent, or Legal Guardian)