Family Medical Eye Center

We are so pleased that you have chosen us to take care of your vision

Chart #_____Date:_____

Name:_____ Date Of Birth:_____

Mailing Address: _____City_____State_____Zip_____

Physical Address:_____City_____State_____Zip_____

Home Phone: _____ Cell Phone_____ Work_____

Social Security Number: _____Drivers License #:_____ State Issued:_____

Race: _____ Preferred Language: _____ Email Address: _____

Marital Status:_____ Spouses Name: _____ Phone:_____

Emergency Contact: _____Phone:_____Relationship:_____

___Employed ____Retired Name of employer:_____

Name of Primary Care Doctor
_____ City _____Phone_____

Name of Doctor Referring You:
_____ City _____Phone_____

Name of Pharmacy_____Location_____

Insurance Information

Primary Insurance

Name_____
Cardholders Name_____
Cardholders Date of Birth_____
ID #_____
Group#_____

Secondary Insurance

Name _____
Cardholders Name_____
Cardholders Date of Birth_____
ID #_____
Group#_____

PLEASE READ AND SIGN

DATE_____SIGNATURE_____
(PATIENT, PARENT, OR POA)

Family Medical Eye Center

Chart #_____Date:_____

Name:_____ Date Of Birth:_____

OTHER SURGICAL HISTORY - Continue on back if more room needed. (Please include date and type.) _____

_____

Are you Allergic to any medication? (YES/NO) If YES Please List: _____

Have you received a flu shot this season? (YES/NO) Current Height_____ Weight_____

Social History: Do you drink any alcohol? Yes____ No_____
Smoking Status: Never ___ Current every day smoker ____ Former Smoker ____ Chewing Tobacco____

EYE HISTORY - Have you been diagnosed with any of the following?

Yes	No (please circle)		Yes	No	
▯	▯	Cataracts _____	▯	▯	Eye injury _____
▯	▯	Corneal disease _____	▯	▯	Iritis _____
▯	▯	Crossed eyes / lazy eye _____	▯	▯	Retina disease _____
▯	▯	Glaucoma _____	▯	▯	Other eye disorders _____

Cataract Surgery (Date of surgery) Right _____ Left _____Other eye surgery _____

MEDICAL HISTORY - Have you been diagnosed with any of the following?

Yes	No		Yes	No	
▯	▯	Asthma/COPD _____	▯	▯	Migraines _____
▯	▯	Cancer _____	▯	▯	Pyschiatric/Anxiety/Depression_____
▯	▯	Carotid artery disease _____	▯	▯	Rheumatoid Arthritis/Osteoarthritis _____
▯	▯	Diabetes Type ___ # of years _____	▯	▯	Seizures, Convulsions, or fainting _____
▯	▯	Head or spinal injuries _____	▯	▯	Stroke _____
▯	▯	Heart disease _____	▯	▯	Thyroid Disorder _____
▯	▯	High blood pressure _____	▯	▯	(Women) Are you pregnant? _____
▯	▯	Kidney Disease _____	▯	▯	Other _____

FAMILY HISTORY (Has anyone in your family (blood relative) had any of the following in the past?) **(NOTE RELATION TO PATIENT: F-Father M-Mother P-Paternal M-Maternal S-Sister B-Brother GF-Grandfather GM-Grandmother U-Uncle A-Aunt)**

Yes	No		Yes	No	
▯	▯	Cataracts _____	▯	▯	Retinal detachment _____
▯	▯	Corneal disease _____	▯	▯	Other eye problems _____
▯	▯	Crossed eyes / lazy eye _____	▯	▯	Diabetes _____
▯	▯	Diabetic retinopathy _____	▯	▯	Heart Disease _____
▯	▯	Glaucoma _____	▯	▯	Stroke _____
▯	▯	Macular degeneration _____	▯	▯	Other _____

Please See Back

Name: _____ Date of Birth: _____

LIST **ALL** PRESCRIPTION, OVER –THE-COUNTER MEDICATIONS AND EYE DROPS YOU ARE CURRENTLY TAKING. INCLUDING VITAMINS, HERBAL SUPPLEMENTS.

PLEASE LIST AS INDICATED ON EACH BOTTLE

NAME OFMEDICINE	HOW MUCH	TIMES PER DAY	HOW LONG	WHAT FOR

PATIENT RIGHTS REGARDING PROTECTED HEALTH INFORMATION

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes that it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

You may revoke this authorization at any time, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contract of your complaint. We will not retaliate against you for filing a complaint. Please direct your complaints to the office manager.

This notice was published and becomes effective on or June 2003

Your signature below acknowledges that you have received and accept this notice of our privacy practices.

Patient Name:_____ DOB_____

Patient Signature:_____ Date:_____

PLEASE MARK ALL THAT APPLY:

❑ Signature above is not the patient's signature. Please print signee's name and relationship to patient (i.e. Legal Guardian/ Parent, POA, Caregiver, etc.)_____

❑ I authorize Dr. Fox and his staff members to leave messages on my home/cell/work number(s) regarding appointments and billing questions.

❑ I authorize Dr. Fox and his staff members to discuss my protected health information with the following people:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

HIPAA NOTICE OF PRIVACY PRACTICES FOR THE OFFICE OF
ROBERT C. FOX, MD, INC
2216 BUENAVENTURA BLVD
REDDING, CA 96001

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

DISCLOSURES FOR HEALTH TREATMENT

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

DISCLOSURES FOR HEALTHCARE OPERATIONS

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this form, speak with our office manager in person or by phone.

We reserve the right to change the terms of this notice and will inform you of any changes.

DISCLOSERS FOR PROVIDER COMPENSATION

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for the treatment.