Dr. Don Robinson, O.D.

WELCOME BACK TO OUR OFFICE

Today's Date ______________________

Patient Information

Last ______________________________
First ____________________ MI ____________
Street ______________________________
City ______________ State ______________
Zip Code ____________________________
Home Phone __________________________
Work Phone __________________________
Cell Phone ___________________________
Patient's SSN ________________________
Employer (or School) __________________
Occupation (or Grade) _________________
Spouse (or Parent's Name) ______________
Spouse (or Parent's Work) ______________
Date of Birth ___________________ Age ________
Sex M F
Email Address ________________________

What is the major purpose of this visit?
____
____
____

Any problems with your current contact lenses or glasses?
____
____
____

Our Mission:

Technology

Education

Compassion

Health

Quality of Life…Quality for Life

Insurance Information

Vision Insurance ______________________
Subscriber Name ______________________
Subscriber SSN ___________________
Subscriber Birth Date __________________

Primary Medical Insurance ______________
Subscriber Name ______________________
Subscriber SSN ___________________
Subscriber Birth Date __________________

Do you participate in a flex spending account?
❑ Yes ❑ No
How will you settle your account today?
❑ Cash ❑ Check ❑ Credit Card

Lifestyle Questions

Do you…… (check box if your answer is yes)
❑..work at a computer? If so, ______Hrs/week
❑..think you might benefit from thinner, lighter lenses?
❑..have interest in a "test drive" of the latest contact lens designs
❑..spend time outdoors? How much? __Hrs/week
❑..have prescription sun wear?
❑..prefer not to wear your glasses at times?
❑..want information on Laser Vision Correction surgery?
❑..have more than 1 pair of current Rx eyewear?
❑..have children?
❑..have family members in need of eye care?

Have you ever experienced, been diagnosed or treated for any of the following?

❑ Blurry Vision
❑ Cataracts
❑ Crossed eye/Eye turn
❑ Eye Infections
❑ Flash of light
❑ Glaucoma
❑ Headaches
❑ Itchiness
❑ Macular Degeneration
❑ Retinal Detachment
❑ Tearing
❑ Uncomfortable glasses
❑ Other eye disorders ______________________
❑ Burning
❑ Corneal Abrasions
❑ Double Vision
❑ Eye Injury
❑ Floaters/Spots
❑ Grittiness
❑ Iritis/Uveitis
❑ Lazy Eye
❑ Occasional dryness
❑ Sunlight Sensitivity
❑ Trouble seeing at night

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician________________________
Town________________________
Date of Last Physical Check-up________________________

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)________________________
____
____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?________________________
____

Have you had any surgeries? ❑ Yes ❑ No
Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?

❑ Allergies	❑ Arthritis
❑ Blood/Lymph	❑ Bronchitis
❑ Cancer	❑ Cholesterol
❑ Diabetes	❑ Digestive
❑ Ears/Nose/Throat	❑ Endocrine
❑ Eczema/Rashes	❑ Fatigue
❑ Fevers	❑ Genitourinary
❑ High Blood Pressure	❑ Integamentory (Skin)
❑ Kidney	❑ Muscle/Bone
❑ Neurological	❑ Psychological
❑ Respiratory	❑ Sinus
❑ Throat Infections	❑ Thyroid
❑ Unusual weight losses/gains	

Patient Eye History

Date of Last Eye Exam________________________
By Whom?________________________

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?________________________
Solutions used________________________

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:

	Relationship (Mother's or Father's side)
Blindness	❑________________
Cataracts	❑________________
Corneal Problems	❑________________
Diabetes	❑________________
Glaucoma	❑________________
Heart Disease	❑________________
Lazy Eye	❑________________
Macular Degeneration	❑________________
Retinal Problems	❑________________

NOTICE OF PRIVACY PRACTICES

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for ***treatment*** *purposes are: setting up appointments for you; testing or examining your eyes; prescribing glasses, contact lenses or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care, low vision aids, or services; and getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for* ***payment*** *purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" means 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 insurance personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records. In some limited situations, the law allows or requires us to use or disclose your health information without you permission. Not all of these situations apply to us; some may never come up at our office at all. Such uses or disclosures are: When a state or 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 notices to and from the federal Food and Drug Administration regarding drugs or medical devices; Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence; Uses and disclosures for health activities, such as: the licensing of doctors; audits by Medicare or Medicaid; or investigation of possible violations of health care laws; Disclosures of judicial and administrative proceedings, such as in response to subpoena or orders of courts or administrative agencies; Disclosures for law enforcement purposes, such as: to provide information about someone who is or 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 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 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 purposes; or for the evaluation and health of members of the Foreign Service; Disclosures relating to worker's compensation programs; Incidental disclosures that are an unavoidable by-product of permitted uses of disclosures; Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.* **I have read and understand the NOTICE OF PRIVACY PRACTICES.**

SIGNATURE____DATE_____/_____/________