PATIENT DEMOGRAPHICS

BOGHOSSIAN VISION

Name: _____ _____ _____
Last First Middle

Date of Birth: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

How did you hear about us? (Please choose as many as applicable)

☐ Family/Friend _____
☐ Internet Search
☐ Yelp.com
☐ Health Insurance
☐ Vision Insurance
☐ Building Sign
☐ Other
_____

Insurance Information

Health Insurance ☐ Yes ☐ No. Health Insurance Name: _____

Vision Insurance ☐ Yes ☐ No. Vision Insurance Name: _____

Primary Insured Name: _____ Date of Birth: _____

VSP Only: Primary Insured Last 4 Digit of Social Security Number _____

I have been informed of the Notice of Privacy Practices and have received a copy.

_____ _____
Signature of Patient Date

I give permission to Boghossian Vision to contact me by text, phone and email.

_____ _____
Signature of Patient Date

PATIENT HEALTH HISTORY

Reason for Visit: ☐ General Eye Exam
☐ Laser Vision Consultation
☐ Other _____

Ocular History	Self History	Family History
Keratoconus	☐ Yes ☐ No	☐ Yes ☐ No
Pellucid Margin	☐ Yes ☐ No	☐ Yes ☐ No
Dry Eyes	☐ Yes ☐ No	☐ Yes ☐ No
History of herpes eye	☐ Yes ☐ No	☐ Yes ☐ No
Amblyopia/Lazy Eye	☐ Yes ☐ No	☐ Yes ☐ No
Fuch's Dystrophy	☐ Yes ☐ No	☐ Yes ☐ No
Avellino Corneal Dystrophy	☐ Yes ☐ No	☐ Yes ☐ No
Sjogren's Disease	☐ Yes ☐ No	☐ Yes ☐ No
Recurrent Corneal Erosion	☐ Yes ☐ No	☐ Yes ☐ No
History of Eye Infections	☐ Yes ☐ No	☐ Yes ☐ No
Eye Injury/Trauma	☐ Yes ☐ No	☐ Yes ☐ No
Corneal Scar	☐ Yes ☐ No	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No
Macular Degeneration	☐ Yes ☐ No	☐ Yes ☐ No
Other _____		

Surgical History

Eye Surgery History ☐ Yes ☐ No
If yes, please list: _____

General Surgery History ☐ Yes ☐ No
If yes, please list: _____

Family Eye Surgery History ☐ Yes ☐ No
If yes, please list: _____

Medical History

Anxiety	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Autoimmune Dis.	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No
Bipolar	☐ Yes	☐ No
Collagen Vascular Dis.	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No
HIV	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Keloids	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Lupus	☐ Yes	☐ No
Migraines	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No
Osteoarthritis	☐ Yes	☐ No
Rosacea	☐ Yes	☐ No
Rheumatoid	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Seasonal Allergy	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No

Other _____

Medications: ☐ Yes ☐ No
If yes, please list name and dosage: _____

Medication allergies? ☐ Yes ☐ No
If yes, please list: _____ Type of Reaction _____

Additional allergies? Adhesive tape - ☐ Yes ☐ No Iodine/Betadine - ☐ Yes ☐ No Latex - ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

For women only: Are you currently pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

Do you wear eyeglasses? ☐ Yes ☐ No **How old are your current eyeglasses?** _____
Do you wear contact lenses? ☐ Yes ☐ No **Contact lens brand:** _____ **Last day worn:** _____

Are you interested in laser vision correction? ☐ Yes ☐ No
Have you been evaluated for LASIK before? ☐ Yes ☐ No Where: _____
If yes, what was the recommendation? ☐ LASIK ☐ PRK ☐ I was told that I am not a candidate

Health Insurance Billing Consent

It is important that you understand that medical exam and testing must be billed through your health insurance. Vision insurance does not cover any visits or testing related to medical reasons. These tests are subject to additional co-pays and deductible that are set by your insurance company. It is difficult to estimate your cost since every health insurance coverage, deductible and co-pays are different.

By signing this form, you understand that these visits are billed to your health insurance and you are responsible for all associated co-pays and deductibles.

Signature: _____

Name: _____

Date: _____

Notice of Privacy Practices

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examinations and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy and to make informed decisions when authorizing disclosure to others.

OUR DUTIES:

Boghossian Vision is required to maintain the privacy of your health information. In addition, we must provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. Boghossian Vision must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will post any revisions to our notice and provide you a new notice at your request. If we maintain a Web site that provides information about our customer services or benefits, we will post our notice on that Web site. We will not use or disclose your health information without your authorization, except as described in the notice.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS:

We will use your health information for treatment. For example: Information obtained by a healthcare practitioner will be recorded in your record and used to determine the course of treatment that should work best for you.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. This information may be necessary for us to receive payment or for you to be reimbursed.

We will use your health information for regular health operations. For example: Members of the medical staff, the risk or quality improvement manager, or members of quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

WAYS IN WHICH WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include certain lab tests, a copy service, and medical record retention services. When services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we've asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information in compliance with HIPAA and the HIPAA regulations.

Appointment and Patient Recall Reminders. We may ask that you sign in writing at the receptionists' desk a "sign in" log on the day of your appointment with the practice. We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with the practice or that you are due to receive periodic care from the practice.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition.

Communication with family: Health professionals, using their best judgement, may disclose to a family member, other relatives, close personal friends or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: Under certain circumstances, we may use and disclose medical information about you for research purposes regarding medications, efficiency of treatment protocols and the like. All research projects are subject to an approval process, which evaluates a proposed research project and its use of medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We will obtain an Authorization form from you before using or disclosing your individually identifiable health information unless the authorization requirement has been waived. If possible, we will make the information non-identifiable to a specific patient. If the information has been sufficiently de-identified, an authorization for the use or disclosure is not required.

Coroners and funeral directors: *We* may disclose health information to a coroner to help determine the cause of death or to identify the deceased. We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations*: Consistent* with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing*:* We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Required by Law*: We* will disclose medical information about you when required to do so by federal, state or local law.

Workers compensation*: We* may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Correctional institution*: Should* you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals. An inmate does not have the right to the Notice of Privacy Practices.

Investigation and Government Activities*: We* may disclose medical information to a local, state or federal agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the payer, the government and other regulatory agencies to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes*:* If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. This is particularly true if you make your health an issue. We may also disclose medical information about you in response to subpoena, discovery, request, or other lawful process by someone else involved in the dispute. We shall attempt in these cases to tell you about the request so that you may obtain an order protecting the information requested if you so desire. We may also use such information to defend ourselves or any member of our practice in any actual or threatened action.

Law enforcement*:* We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process
- To identify or locate a suspect, fugitive, material witness or missing person
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of criminal conduct
- About criminal conduct of the Practice; and
- In emergency circumstances to report a crime: the location of the crime or victims or the identity, description or location of the person who committed the crime.

CHANGES IN THIS NOTICE

We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we may receive from you in the future. We will post a copy of the current notice in the practice.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the practice or the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact the Administrator, who will direct you on how to file an office complaint. All complaints shall be investigated, without repercussion to you.
You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization, unless those uses can be reasonably inferred from the intended uses above. If you have provided us with your authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.