WELCOME TO OUR OFFICE

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. _____ _____ _____
Last Name First Name Middle Name

Gender: ☐ Male ☐ Female Date of Birth: ____/____/____ _____ _____
MM / DD / YY Age Employer Occupation

_____ _____ _____ _____ _____
Street Address Apt. # City State Zip Code

_____ _____ _____
Cell Phone Alt. Phone (Home or Work or Other) circle one E-mail

REFERRAL If you were referred by someone, whom may we thank? _____

GENERAL EYE HISTORY *(Please check all that apply).*

	Self	Family
Blur at distance w/o glasses or contacts	❑	
Blur at near w/o glasses or contacts	❑	
Blur at computer w/o glasses or contacts	❑	
Dry eye	❑	
Double vision	❑	
Lazy eye *(Poor vision even with correction)*	❑	
Eye injury	❑	
Eye surgery	❑	
Flashes	❑	
Floaters *(Little black dots or lines inside eyes)*	❑	
Glaucoma	❑	❑
Other _____	❑	❑
None of the above	❑	❑

Date of last eye exam: _____
What was the outcome of the exam: ☐ Glasses ☐ Contacts
☐ No prescription needed ☐ Other _____

Contact Lens History
☐ I would like to know my contact lens options
☐ I am not interested in contact lenses.

GENERAL HEALTH HISTORY

	Self	Family	
Headaches	❑		
Pregnant (if applicable)	❑		If Any, Who?
High blood pressure	❑	❑	_____
Cardiovascular disease	❑	❑	_____
Diabetes	❑	❑	_____
Lung disease	❑		
Hyperthyroidism	❑		
Hypothyroidism	❑		
Seasonal allergies	❑		
Drug Allergies	❑		_____
Other _____	❑	❑	
None of the above	❑	❑	

Have you ever abused drugs or alcohol? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No
Please list any medications: _____

_____

REASON FOR TODAY'S VISIT

❑ Regular check-up ❑ Prescription has changed ❑ Broke glasses / Lost glasses or contacts ❑ Other _____
_____

ADDITIONAL TESTINGS

EyeScreen

EyeScreen is a high resolution screening photograph of your retina which will help us document, review, and compare your retina over time. We use the EyeScreen exam to document a baseline image for our records, screen for eye disease and improve our ability to view your internal retinal health at a much higher resolution than a slit lamp or ophthalmoscope. We are concerned about any retinal problems which can lead to partial loss of vision or blindness. Additionally many symptoms of systemic diseases such as diabetes and the effects of high blood pressure can be detected with the EyeScreen Examination. The fee for this part of the exam is $**35**

VISUAL FIELDS TEST

The visual fields test is a computerized test that allows us to check for blindspots in your vision. Visual fields analysis can assist us in early detection of glaucoma, some neurological disease (such as brain tumors and optic nerve disease), and retinal defects. Visual fields testing also enable us to better diagnose causes of headaches. Unlike the pupil dilation, this test does not require us to put eye drops in your eyes. The fee for this part of the exam is **$30**

☐ **YES, I want my Eyescreen to check my retina.**
☐ **YES, I want the visual fields test.** ☐ **NO, I do not want either test.**

I have been informed of Eagle Eye Associate's Privacy Practices.

_____ _____
Patient's signature (Parent or legal guardian if patient is under 18 years old) Date

Please Note: ALL FEES PAID FOR PROFESSIONAL SERVICES ARE NON-REFUNDABLE AND ARE PAYABLE AT THE TIME OF SERVICE.

Eagle Eye Associates NOTICE OF PRIVACY PRACTICES

4122 Lyndon B Johnson freeway Dallas, Tx 75244
Effective 04-15-2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION; THE "**OFFICE**" PERTAINS TO "Eagle Eye Associates." PLEASE REVIEW IT CAREFULLY.

The office is required by law to maintain the privacy of your health information, to follow the items of this notice, and to provide you with this notice of our and privacy practices. We will not use or disclose medical information about you without your written authorization, except as described in this NOTICE. If your state law provides additional restrictions upon any of the forgoing uses and disclosures, we must follow your state law.

How the Office May Use or Disclose Your Health Information

- ***Treatment, Payment, and Regular Health Care Operations*** - Information obtained by the Office will be used to dispense and provide prescription ophthalmic goods and services to you, bill your insurance carrier if you have third party coverage, and to record and monitor the service provided to you. Information will also be provided to you upon your request.
- ***As and When Required by Law*** – We may use and disclose your health information to Public Health Officials, Health Oversight Activities (For audits, investigations, etc.), Judicial and Administrative, Deceased Person Information, Worker Compensation Programs, Food and Drug Administration (for reporting adverse drug events and quality issues), if there is a serious threat to your health or safety, in times of National Security, if you are in the Military or a Veteran of the armed forces, or if you become an inmate in a correctional facility.
- ***Personal Communications*** – We may contact you or individuals involved in your care or payment of your care to provide appointment reminders, annual eye examination cards and other information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- ***Disclosure to Our Business Associates*** – We may provide some services through contracts with business associates (accounting, etc.) When necessary, we may disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your health information, we require our business associates to appropriately safeguard your health information.
- ***Victims of Abuse, Neglect, or Domestic Violence*** – We may disclose your health to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

Marketing Communications. We must obtain your written authorization prior to using your health information to send you any general marketing materials. We may contact you about products or services relating to your treatment, care, or alternative treatments, or providers without prior authorization.

Your Rights with Respect to Your Health Information

- You have the right to request restrictions on certain uses and disclosures of your health information. The Office is not required to agree to the restriction that you requested.
- You have the right to inspect and copy your health information (prescription, billing records, etc.) as long as the Office maintains the health information. To inspect or copy your health information, you must submit a written request to the location that provided your services. We may charge you a fee for the cost of copying, mailing, or other supplies that are necessary to grant your request. We may deny your request to inspect and copy under certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed. You have the right to request that the Office amend your health information that is incorrect or incomplete. The office is not required to change your health information and will provide you with information about the procedure for addressing any disagreement with the denial.
- You have the right to receive an accounting of disclosures of your health information we have made since April 14, 2003 for most purposes other than treatment, payment, health care operations provided to you, and certain government functions. You must specify the time period but be no longer than six years. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time.
- You may request communications of your health information by alternative means or at alternative locations. For example, you may request that we contact you about medical matters or at a different residence or post office box. Your request must state how or when you would like to be contacted. We will accommodate all reasonable requests.

If you would like to exercise one or more of these rights, need additional information, or believe your privacy rights have been violated, contact the location that provided your services at the address above. There will be no retaliation.

Changes to this Notice of Privacy Practice

The Office reserves the right to amend our practices and this Notice of Privacy Practices at any time in the future and to make the new Notice effective for all medical information we maintain. Until such amendment is made, the Office is required by law to comply with this Notice.

☐ I authorize the disclosure of my health information as described on this form.
☐ I do not authorize the disclosure of my health information as described on this form.

Patient's/Guardian's signature: _____ Date: _____