Buffalo Niagara Retina Associates

Phone: 716-631-3300 Fax: 716-631-3303

Dear _____,

We currently have an appointment reserved for you with Dr. _____.

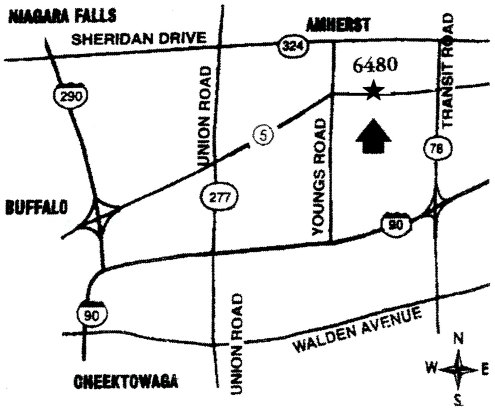
Your appointment is scheduled for: Date: _____ Time: _____.

You will be seen at the following office location:

Office Park of Williamsville

6480 Main Street, Suite 1
Williamsville, NY 14221

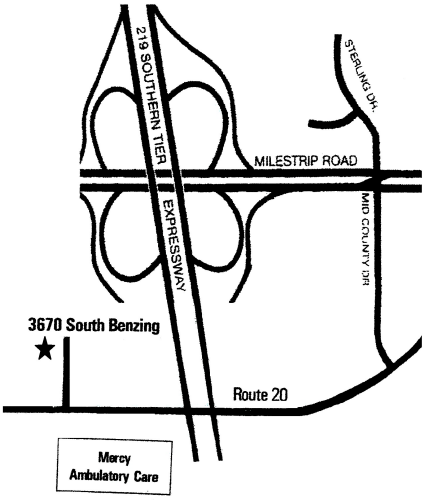
☐



The Benzing Commons

3670 South Benzing Road, Suite J
Orchard Park, NY 14127

☐



Please bring to your appointment:

- A driver
- Photo identification
- Insurance card
- List of current medications
- Glasses
- Sunglasses

If you cannot make your appointment, please give our office 24 hours notice.
A normal office visit is 1½ to 2 hours.

BUFFALO NIAGARA RETINA ASSOCIATES

MEDICAL HISTORY QUESTIONNAIRE

Full Legal Name: _____ **Sex:** ☐ M ☐ F **Date of Birth:** _____ **Date:** _____

If this is your first visit, please complete:

How did you hear about us? ☐ Doctor ☐ Friend ☐ Family Member ☐ Internet ☐ Other: _____

Date of last eye exam: _____ Where was this done (doctor/clinic)? _____

Referring Eye Doctor: _____

Primary Care Doctor: _____

Are you currently taking: ☐ Flomax ☐ Coumadin ☐ Plavix ☐ Aspirin ☐ Rapaflo ☐ Other Blood Thinner
☐ Uroxatral ☐ Minipress ☐ Cardura ☐ Hytrin ☐ Avodart

Current Medications (prescription, over the counter, vitamins, homeopathic): _____

_____

_____

_____

Allergies to medications: _____

Have you ever had any of the following eye procedures: ☐ LASIK ☐ PRK ☐ RK ☐ AK
☐ CATARACT SURGERY RIGHT _____ LEFT _____

List **all current & previous** illnesses, injuries, surgeries: _____

_____

_____

Please check any of the following conditions that you have **TODAY:**

General:	☐ fever	☐ fatigue	☐ cancer Type:	
Ears, Nose, Throat:	☐ earache	☐ nasal congestion	☐ pain	
Cardiovascular:	☐ chest pain	☐ high blood pressure	☐ irregular/ rapid heartbeat	☐ high cholesterol
		☐ pacemaker	☐ congestive heart failure	
Gastrointestinal:	☐ reflux	☐ diarrhea	☐ vomiting	
Genitourinary:	☐ trouble urinating	☐ discharge	☐ ulcer	
Integumentary:	☐ skin cancer	☐ acne	☐ rosacea	☐ eczema
Musculoskeletal:	☐ arthritis	☐ gout	☐ joint pain	☐ muscle pain
Neurological:	☐ numbness	☐ memory loss	☐ dizziness	☐ stroke
Psychiatric:	☐ anxiety	☐ depression	Other:	
Endocrine:	☐ diabetes	☐ hypothyroidism	☐ Grave's disease	
Hematologic:	☐ high cholesterol	☐ anemia	☐ bleeding disorder	
Immunologic:	☐ allergies	☐ immune disorder		
Repiratory	☐ asthma	☐ emphysema	☐ shortness of breath	

Do any of your blood relatives have the following conditions:

Blindness:	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Glaucoma:	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Macular Degeneration:	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Diabetes:	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Retinal Detachment:	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Heart Disease	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
High Blood Pressure	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Cancer	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent

Social History:

Do you currently drive?	☐ No	☐ Yes		
Do you smoke:	☐ No	☐ Yes		
Have you ever smoked?	☐ No	☐ Yes	When did you quit?	
Are you pregnant?	☐ No	☐ Yes	Expected Due Date?	
Are you nursing?	☐ No	☐ Yes		
Are you working?	☐ No	☐ Yes	☐ Retired	Occupation:
Do you drink?	☐ No	☐ Yes		

Buffalo Niagara Retina Associates

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I, _____, have received a copy of **BUFFALO NIAGARA RETINA ASSOCIATES** Notice of Privacy Practices.

I give my permission to release information regarding my medical condition and treatment to the following persons:

(ie: Friends/Relatives. Please do not list medical providers)

Name:_____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Signature of Patient: _____

Date Signed: _____

Registration :

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #

Address	Home Phone Work Phone Cell Phone	How did you hear of us?
Address 2	Email:	

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact	Phone	Pharmacy	Phone

Pref Language:	Race:	Ethnicity:	County:

Provider	Family Physician	Referring Physician

Medical Insurance	Name & Address	Policyholder	Relationship	Copay	Policy ID	Group ID
1						
2						
3						

Policyholders/Guarantors (Person to be billed, if different than patient)

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work Phone	Email:

City	State	Zip Code	Employer Name & Address	Occupation

HIPAA Approved Contacts

1. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work Phone

Ethnicity/Race

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Buffalo Niagara Retina Associates , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date	
X		Phone: Email:

Please attach all pertinent insurance ID cards for photocopying.

BUFFALO - NIAGARA RETINA ASSOCIATES NOTICE OF PRIVACY PRACTICES

This notice describes our medical information about you maybe used and disclosed and how you can get access to this information please review it carefully.

Protected Health Information (PHI) may be released without individual authorization for treatment, payment or healthcare operations (e.g. to ensure, referral/consults, prescriptions to pharmacies, emergency treatment situations, quality reviews, etc.) to those required by law including:

- The Secretary of Department of Health and Human Services for investigating compliance/enforcement
- Public health purposes (i.e. communicable diseases)
- Health oversight activities
- Judicial and administrative proceedings
- Law-enforcement
- Workers compensation
- "Specialize government functions"
- Research with IRB or Privacy Board approval of waiver
- FDA in respect to an FDA-regulated product or activity for which that person has responsibility, for the purpose of Activities related to the quality, safety ,or effectiveness of the FDA-regulated product or activity.

Patients have the right to access their own protected health information information (PHI) through written request (exemption: mental health records). Copies of records will be provided according to NYS Public Health Law 18 at the rate of $.75/pg - patients to demonstrate the inability to pay will have the record provided at no charge.

Patients have the right to "authorize" third parties to receive protected health information (PHI). They also have the right to revoke prior authorizations. This must be done in writing.

Patients may request restrictions on disclosures to others of their protected health information (PHI). This must be requested in writing. Patients may request a restriction but the request does *not* have to be granted.

This office may call a patient to confirm appointments. (Patients may request alternative means of communicating protected health information (PHI) which is considered "reasonable".)

Patients may request amendments to their protected health information (HPI) in writing.

- This office will respond within 60 days of the date on the written request
- Denial is permitted if the protected health information (HPI) is accurate or if this office did not create the protected health information (HPI).
- If the request is granted, the protected health information (HPI) will be amended according to law, the patient will be informed of the amendment, and other related healthcare providers and business associates will be notified as indicated.
- If the request is denied, this office will provide a written denial to the patient explaining the reason for denial and the patient's rights.

Upon written request, patients will be given an accounting of unauthorized disclosures of their protected health information (HPI).

Exemptions :

- for treatment, payment and healthcare operations
- to individuals themselves
- to others involved in the patient's care
- for national security
- to law enforcement (with limits)
- occurring prior to compliance date
- authorized disclosures

This office is required by law to maintain the privacy of protected health information (HPI) into provide individuals with notice of its legal duties and privacy practices with respect to protected health information (PHI).

This office is required by law to maintain the privacy of protected health information (HPI) and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information (PHI).

This office is required to abide by the terms of the notice currently in effect.

This office reserves the right to make changes in its privacy notice and to make new notice provisions effective for all protected health information (PHI) that it maintains. Revised notices will be given to patients as they occur.

Individuals may make a complaint to the privacy office at 716-631-3300 and the Office of Health & Human Services if they their privacy rights have been violated. Please send a complaint in writing with your name, address and date of birth to:
PRIVACY OFFICER, BUFFALO-NIAGARA RETINA ASSOCIATES, 6480 Main Street - Suite#1, Williamsville, NY 14221.
There will not be any retaliation for filing a complaint with the Buffalo-Niagara Retina Associates Privacy Officer. this privacy notice will be in effect as of April 13, 2003.