RICHARD L. STORM, M.D., P.C.

NAME:_____M__F__

ADDRESS:_____APT #_____

CITY:_____ST_____ZIP_____

HOME PHONE:_____CELL PHONE:_____

E-MAIL:_____

DATE OF BIRTH:_____AGE:_____SS #_____-_____-_____

EMPLOYED:_____YES_____NO BUSINESS PHONE:_____

MEDICAL DR:_____

INSURANCE:_____

2ND INSURANCE:_____

PRESCRIPTION DRUG PROGRAM?: YES_____ NO_____

PHARMACY NAME:_____PHONE #:_____

IN CASE OF EMERGENCY NOTIFY:_____

RELATIONSHIP:_____PHONE #:_____

I UNDERSTAND THAT REGARDLESS OF MY INSURANCE STATUS, I AM RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED.

SIGNATURE:_____DATE:_____

PARENT SIGNATURE, IF MINOR:_____

Name: _____ Phone # _____

Address _____ Date _____

Date of **Birth** _____ Date of **last eye exam** _____

List any **medications** you currently take (Rx and over-the-counter): _____

_____

Do you have **allergies** to any medications? **YES NO**
If YES, list the medications: _____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

_____

List any **surgeries** you have had (cataract, appendectomy): _____

Do you ***currently*** have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply) ? **YES NO UNKNOWN**

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES NO**
Have you ever had a blood transfusion?..... **YES NO**
Do you drink alcohol?..... **YES NO** If YES, how much? _____
Do you smoke?..... **YES NO** If YES, how much? _____ How many years? _____

Physician's Signature _____ *Date* _____

RICHARD L. STORM, M.D., PC

303 East Park Avenue
Long Beach, N.Y. 11561

161 Atlantic Avenue
Brooklyn, N.Y. 11201

HIPAA PRIVACY NOTICE

(Effective 4/14/03)

1. This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information.
2 This office has always recognized the importance of privacy; this new federal law formalizes practices that have been followed routinely.
3. Background: In 1996 Congress recognized the need for national patient privacy standards and as part of the Health Insurance Portability and Accountability Act, abbreviated HIPPA, ordered that a set of rules be established to control how health information is used and disclosed, as maintained by doctors, hospitals and health plans. Health information is considered sensitive and personal, and the law establishes consumer protection and limits the sharing of such information, as do similar protections already enacted for bank accounts, credit cards and even video rentals.
4. By the law, consent is not required to discuss your medical treatment with your other doctors or health care providers. This allows, also for a prescription to be called into your pharmacy and for scheduling surgery in a hospital.
5. Additionally, none is needed in the course of carrying out health care operations, such as quality assessment, or in communication with your insurance carrier for payment related issues, or for incidental uses, such as announcing a name in a waiting room or the us of sign-in sheets.
6. However, this office has always gone one step further in protecting you and does not believe in releasing specific information about you to any business or governmental entity without your written consent.
7. Specific authorization is required to disclose protected information in a non-routine circumstance, such as to your employer for us in marketing a product to you.
8. Medical information about you may be released for research and public health uses, as long as you are not individually identified.
9. You are guaranteed access to review when and to whom your information was released.
10. You may suggest additional restrictions with regard to certain uses and disclosures, if you wish.
11. Portions of this notice may be modified, as long as you are notified.
12. Should you believe that your privacy rights have been compromised, you may report the violation, without penalty to you, to this office or to the Secretary of Health.
13. The law required that you acknowledge receipt of this notice; this has been included on the signature release on your registration form or on the bottom of this notice.

14. Date _____

15. Signature _____

RICHARD L. STORM, M.D., P.C.

Patient Consent For The Use and Disclosure of Protected Health Information

With my consent, Richard L. Storm, M.D., P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent Richard L. Storm, M.D., P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Richard L. Storm, M.D., Privacy Officer at 303 East Park Avenue, Long Beach, New York 11561 or 161 Atlantic Avenue, Brooklyn, New York 11201.
With my consent, Richard L. Storm, M.D., P.C. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Richard L. Storm, M.D., P.C. may mail to my home or other designated location any items that assist in the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Richard L. Storm, M.D., P.C. may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Richard L. Storm, M.D., P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Richard L. Storm, M.D., P.C. use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Richard L. Storm, M.D., P.C. may decline to provide treatment to me.

_____

Signature of Patient of Legal Guardian

_____ _____

Patient's Name Date

_____

Print Name of Patient or Legal Guardian