CLIFFSIDE EYE CENTER
PATIENT OCULAR & MEDICAL HISTORY FORM

Name:	**Date:**
Age:	**Medical Doctor:**
Diabetic? Yes No # of years:	**Previous Eye Doctor:**
Referred by:	**Last Eye Exam:**
☐ Friend ☐ Brochure ☐ Internet ☐ Insurance ☐ Doctor	**e-mail address:**

☑ **Reason for this visit:** ☐ Yearly exam to have glasses / contacts checked ☐ Vision has changed ☐ Diabetic Evaluation ☐ Cataract Evaluation ☐ Second Opinion ☐ LASIK Evaluation

☑ **Any eye symptoms you have had:**

☐ Blurred Vision	☐ Burning	☐ Eye Fatigue
☐ Dryness	☐ Stinging	☐ Light Sensitivity
☐ Cataracts	☐ Itching	☐ Headaches
☐ Spots / floaters / flashes	☐ Tearing	☐ Migraines
☐ Reading Difficulty	☐ Redness	☐ Diabetes
☐ Glare / Halos /	☐ Tired Eyes	☐ Poor Night Vision / Night driving difficulty
	☐ Pressure	☐ OTHER_____

LIST MEDICATIONS/PILLS:

LIST EYE DROPS:

DRUG ALLERGIES: ☐ No ☐Yes Please list:

Pharmacy Name/Town

Past, Medical, Family and Ocular History

	Medical History & System Review	Ocular History		
☑		*Self*		*Family*
☐	High blood pressure	☐	Cataracts	☐
☐	Heart Condition:	☐	Glaucoma	☐
☐	Diabetes YES / NO YEARS=_____	☐	Macular Degeneration	☐
☐	Cancer:	☐	Dry Eyes	☐
☐	Arthritis	☐	Amblyopia/Lazy Eye	☐
☐	Respiratory Disease:	☐	Retinal Disorders	☐
☐	Ear / Nose / Throat Problems:	☐	Infections	☐
☐	Circulation Problems:	☐	Eye Surgery	☐
☐	Neurological Problems:	☐	Laser Treatment	
☐	Allergies:	*Other:*		
☐	*Other:*			

Social History: Please indicate your use of the following:
Alcohol _____# of drinks per week Smoking ____# cigarettes per day ___ yrs
Do you drive? ☐ Yes ☐ No Hobbies & special interests:_____
What type of eyeglass lenses do you currently wear? ☐ Single Vision ☐ Bifocal ☐ Progressive
Are you satisfied with your current glasses? ☐ yes ☐ no If no, explain _____
What type of contact lenses do you wear? ☐ soft ☐ disposable ☐gas perm.
How many hours per day do you use a computer? ☐ 1-3 hrs ☐ 3-6 hrs ☐ 6+ hours

Questions: _____

UPDATED: 1 2 3 4 5 6 7 8 9 10 11 12 / 20____ **PATIENT SIGNATURE**_____

MD SIGNATURE_____

CLIFFSIDE EYE CENTER
RICHARD LEVINE, MD

HIPPA AND PROTECTECTED HEALTH INFORMATION (PHI)

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

The Notice of Privacy Practices describes how Protected Health Information about you may be used and disclosed and how you can get access to this information. For more information and to view the policy in its entirety, visit the U.S. Department and Human Services webpage www.hhs.gov. Cliffside Eye Center, LLC is required by law to protect the privacy of health information that may reveal your identity. Patient's information will be kept confidential and handled appropriately. This specifically includes the sharing of information with other health care providers, laboratories, pharmacies, and health insurance payers as is necessary and appropriate for your care. Protected Health Information is information about you, including demographic information, that may identify you as well as genetic information, and information that relates to your past, present or future physical or mental health or condition and related health care services.

Keeping our patient's information private is important to us, and by default we will disclose information related to the patient's medical conditions only to the patient or legal guardian. Please let us know if you would like to authorize Cliffside Eye Center and Richard Levine, M.D. to discuss your medical care with:

Contact Name/Emergency Contact	Relationship to Patient	Contact Phone Number

By signing below, I certify that I have received and understand the Notice of Privacy Practices and consent to the use of my PHI as stated.

PRINT NAME OF PATIENT

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**

Cliffside Eye Center
Authorization for Service(s)

This signed document serves as a general authorization for the following:

I am aware that I am responsible for any fees not covered by my insurance, i.e.: insurance copay or co-insurance, deductible and/or refraction fee when applicable.

Self-Pay I understand that I am fully responsible for all fees associated with services rendered.

Insurance Authorization

I have provided Cliffside Eye Center with a copy of my current insurance coverage. I authorize them to submit claims for services rendered to my carrier.
Additionally, I authorize the release of my medical records to my carrier as indicated to process my claims for payment.

Referrals

I understand that it is my responsibility to determine if a referral is needed under my insurance plan. The referral must be obtained from my primary care physician prior to my visit with Cliffside Eye Center. The undersigned fully understands that he/she is responsible for payment in full if they do not have a referral at the time service(s) are rendered.

X _____ _____

Patient or Guardian's Signature Date