

Beachside Optometry

REGISTRATION FORM

Today's Date:

Family or Primary Care Physician:

PATIENT INFORMATION

Last Name:

First:

Middle:

Marital Status:

Is this your legal name?

If not, what is your legal name?

Dr. Mr. Mrs.

Birth Date:

Age:

Gender:

Male Female

Yes No

Ms. Miss Master

Street Address or P.O. Box:

City:

State:

Zip Code:

Social Security #:

Cell phone #:

Home phone #:

Email Address:

Occupation:

Employer:

Can we email your prescription and/or any other medical information to you? Yes No

How were you referred to us? (Insurance, Yelp, Website, Walk-By, Friend, Family Member, etc.)

Who may we thank for referring you?

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to a receptionist)

Name of Insurance Subscriber/Cardholder:

Birth Date:

Address (if different):

Phone #:

Name of Vision Insurance:

ID #:

Cardholder's SS #:

Primary Medical Insurance: ID #:

PPO or HMO?

If HMO, name of Medical Group?

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of contact:

Relationship to patient:

Cell phone #:

Work phone #:

The above information is true to the best of my knowledge. I (or my dependent) authorize my insurance benefits be paid directly to the Beachside Optometry. I understand that I am financially responsible for any balance leftover. I also authorize Beachside Optometry or my insurance company to release any information required to process my claims. I authorize the use of my signature on all insurance submissions. No refunds are given on glasses or contacts that are already made by our laboratory: remake or exchange only. All orders not dispensed within 30 days of notification will forfeit deposit unless prior arrangements are made.

Patient Signature (or Signature of Parent/Guardian for Minors)

Date

(Continue to next page)

Name: _____

When was your last eye exam? _____

How many hours per day are you on a computer? _____

Do you wear glasses? Yes No

Do you have prescription sunglasses? Yes No

Do you have computer glasses? Yes No

Are you interested in Lasik? Yes No

Do you wear contact lenses? Yes No

If not, would you like to wear contacts? Yes No

Contact lenses require a yearly contact lens evaluation to ensure optimal health and vision. This is not part of a routine eye exam and is not always covered by vision insurance. Before proceeding, please ask a staff member for an estimate of your charges today.

I would like to proceed with a contact lens evaluation today: _____ (please initial)

I decline the contact lens evaluation. I understand that by declining, I will not be able to order contact lenses until an evaluation has been done: _____ (please initial)

Although optometry services focus primarily on your eyes, it is important that we recognize your eyes as part of your entire body. Health conditions you may have or medications you may be taking could have a significant connection with your overall treatment plan in our office.

Please mark all boxes that apply to your own or your family's medical history.

<u>Medical</u>	Self	Family		Self	Family		Self	Family
AIDS or HIV	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hypercholesterolemia	<input type="checkbox"/>	<input type="checkbox"/>			
COPD	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Females: Are you pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

<u>Ocular History</u>	Self	Family		Self	Family		Self	Family
Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>	Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>
Blepharoplasty	<input type="checkbox"/>	<input type="checkbox"/>	Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Blind Eye	<input type="checkbox"/>	<input type="checkbox"/>	Eye Surgery	<input type="checkbox"/>	Type: _____	Ptosis/ Eyelid Droopy	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	Eye Turn	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>
Conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>			

Ocular Symptoms

Abrasion	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	Floaters	<input type="checkbox"/>	Light Sensitivity	<input type="checkbox"/>	Tearing	<input type="checkbox"/>
Blurry Vision	<input type="checkbox"/>	Eye Infection	<input type="checkbox"/>	Grittiness	<input type="checkbox"/>	Night Blurriness	<input type="checkbox"/>	Watery	<input type="checkbox"/>
Burning	<input type="checkbox"/>	Feeling Something in Eye	<input type="checkbox"/>	Headlight Glare	<input type="checkbox"/>	Sandy Feeling	<input type="checkbox"/>		
Crossed Eyes	<input type="checkbox"/>	Flashes of Light	<input type="checkbox"/>	Itchy Eyes	<input type="checkbox"/>	Stinging	<input type="checkbox"/>		

PLEASE TURN OVER TO CONTINUE ON BACK SIDE

Please mark all boxes that apply to your medical history.

<p>Allergic/Immunological</p> <p><input type="checkbox"/> Itchy Skin</p> <p><input type="checkbox"/> Lupus</p> <p><input type="checkbox"/> Rheumatoid</p> <p><input type="checkbox"/> Seasonal allergies</p>	<p>Genital, Kidney, Bladder</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Kidney Stones</p>
<p>Skin</p> <p><input type="checkbox"/> Acne</p> <p><input type="checkbox"/> Growths</p> <p><input type="checkbox"/> Rashes</p>	<p>Gastrointestinal</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Ulcer</p>
<p>Cardiovascular</p> <p><input type="checkbox"/> Heart Surgery</p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> Vascular disease</p>	<p>Neurological</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Migraines</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Seizures</p>
<p>Psychiatric</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Insomnia</p> <p><input type="checkbox"/> Mood changes</p>	<p>General</p> <p><input type="checkbox"/> Excessive thirst</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Sleep troubles</p> <p><input type="checkbox"/> Weight gain</p>

Medications: _____

Drug Allergies: _____

Patient Social History

Use of alcohol Never Rarely Moderate Daily

Use of tobacco Never Previous but quit Currently; Frequency: _____

Use of drugs Never Previous but quit Currently: Type: _____

Excessive exposure to: Fumes Dust Solvents Airborne particles

Acknowledgement of Receipt

I acknowledge that I received a copy of Beachside Optometry, Inc. O.D.,

Notice of Privacy Practices. Date _____

Patient Name _____

Signature _____

BEACHSIDE OPTOMETRY, INC.

10088 Adams Ave.
Huntington Beach, CA 92646
(714) 962-9377



Effective date of notice: April 14, 2003

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, [We will] ask you for special written permission.

[We will ask for special written permission in the following situations:

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;
- [specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photo copies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photo copies if we send you a written notice of the extension. If you want to review or get photo copies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.