Family Vision Care of Richmond

Medical History Questionnaire

Today's Date:_____

Name _____
First MI Last Preferred

Address:_____
Street/Apt City State Zip

Parent/Guardian (If Applicable): _____ Social Security # (last 4):_____ In Case of Emergency Contact:_____

Phone Numbers: (Home) _____ (Work) _____ (Cell) _____

Email Address: _____@gmail.com/@yahoo.com Date of Birth: _____/_____/_____

Race (please circle): American Indian or Alaska Native// Black or African American//Native Hawaiian or Other Pacific Islander//Asian// White

Ethnicity (please circle): Hispanic // Not Hispanic

Occupation: _____Employer:_____

Primary Care Physician/Pediatrician or Specialist: _____Phone Number: _____

Practice/Provider's Electronic health record "Direct" address: _____

Date of Last Physical or Medical Exam:_____ Date of Next Appointment:_____

Name/Location of preferred Pharmacy: _____

Do we have your consent to access your medication history if available (your consent can be revoked at any time)? □ no □ yes

Did you recently fail a school or pediatric vision screening? □ no □ yes If yes, when: _____

Social History:

Smoking (please circle): Current every day smoker Current some day smoker Former smoker Never smoked

Do you drink alcohol? □ no □ yes If yes drinks/day: _____

Do you use illegal drugs? □ no □ yes If yes amount/type: _____

Have you ever been exposed to or infected with (please circle): Gonorrhea Hepatitis HIV Syphilis **□none**

Past Ocular History: Do you have any of the following ocular conditions? (please circle) **□none**

Cataract	Dry Eye	Diabetic retinopathy	Keratoconus	Amblyopia
Double Vision	Iritis/Uveitis	Macular degeneration	Lazy eye (strabismus)	Other_____
Eye Pain	Glaucoma	Retinal detachment	Flashes/Floaters	

Past Ocular Surgeries (please circle and specify which eye and date of procedure): **□none**

Eye muscle surgeries_____	Retinal laser surgery_____	LASIK/PRK_____
Corneal transplant _____	Cataract surgery_____	Other_____

Have you ever had your pupils dilated before? □ no □ yes

Have you ever had a reaction to any eye drops administered during an eye exam? □ no □ yes If yes, explain:_____

Do you wear glasses? □ no □ yes

Do you wear contact lenses? □ no □ yes Brand:_____Power/Rx:_____

Date of your last eye exam?_____ Previous Eye Doctor (name or location): _____

Do you have any allergies to medications? □ no □ yes If yes, explain_____

Are you **pregnant**? □ no □ yes

Are you **nursing**? □ no □ yes

[over]

Personal Medical History: Are you currently receiving treatment or have you previously been treated for any of the following conditions? If so, please circle and explain in the right column (include any medications you may be taking for these conditions) otherwise, please check (√) NONE. **NONE**

Constitutional: Development Disabilities/ Weight Loss/ Weight Gain/Cancer/Other		
ENT: Hearing loss/Ringing in ears/Vertigo/Sinusitis/Laryngitis		
Neurological: Multiple Sclerosis/Epilepsy/Seizures/Migraine/ Headache/Cerebral Palsy/Stroke/Autism/Paralysis		
Psychiatric: Depression/Attention deficit/Anxiety Disorder/ Bipolar/Other		
Cardiovascular: Hypertension/Stroke/Heart disease/Chest pain/ Vascular disease /Congestive heart failure/ High cholesterol		
Respiratory: Asthma/Bronchitis/Emphysema/COPD/Sleep apnea		
Gastrointestinal: Crohn's/ Colitis/Ulcer/Acid reflux/Diarrhea/ Celiac disease/ Vomiting/Hepatitis		
Genitourinary: Kidney disease/Prostate disease or cancer/ History of STDs/Benign prostate hypertrophy		
Musculoskeletal: Arthritis/Osteoporosis/Fibromyalgia/Gout/ Muscular dystrophy/ Ankylosing spondylitis		
Integumentary (skin): Eczema/Rosacea/Psoriasis/Acne/ Herpes simplex (cold sores)/ Herpes zoster (shingles)		
Endocrine: Type 1 diabetes/Type 2 diabetes/ Hyperthyroid/ Hypothyroid/Hormone dysfunction		
Hematologic (blood)/Lymphatic: Anemia/Leukemia/Ulcer/Sickle cell		
Allergic/Immune: Environment allergies/Rheumatoid arthritis/ Lupus/Sjogren's		

***Other: any medical condition not listed above or any over the counter medications or other prescription medications**

Family Ocular History: Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following:

	NO	YES	?	RELATIONSHIP TO YOU
Blindness	□	□	□	_____
Cataract	□	□	□	_____
Crossed Eyes	□	□	□	_____
Glaucoma	□	□	□	_____
Macular Degeneration	□	□	□	_____
Retinal Detachment	□	□	□	_____
Keratoconus	□	□	□	_____
Other	□	□	□	_____

Family Vision Care
of Richmond

Dr. David LeRoux Dr. Patricia Daylor Dr. Tracy Poling
Dr. Jeff Michaels Dr. Stephanie Matsko

4114 Innslake Drive
Glen Allen, VA 23060
p. 804.217.988
f. 804.217.9065
fvcor.com

CONSENT TO DISCLOSE MEDICAL INFORMATION

Please check one of the following:

_____ I give my permission to the employees of Family Vision Care of Richmond to disclose my Protected Health Information to the following family and/ or friends, verbally, in writing or through PHR (Personal Health Records)

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

_____ I request that all my Protected Health Information be disclosed ONLY to me and no other family or friends.

I understand that I may revoke or change this Consent at any time by filling out another consent form to replace this one

Patient's Signature: _____ Date: _____

Patient- Print Name: _____ DOB: _____

Family Vision Care of Richmond, P.C.
Optometrists
Drs. LeRoux, Daylor, Poling, Michaels, & Matsko

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

* **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include glaucoma, cataract, retina, Lasik, etc.
* **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your vision plan for your routine vision services.
* **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected information when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your ' PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under

the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing an we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

* **The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.**
* **The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.**
* **The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.**
* **The right to request an amendment to your PROTECTED HEALTH INFORMATION.**
* **The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.**
* **The right to obtain a paper copy of this notice from us upon request.**

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with the notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

Family Vision Care of Richmond – Drs. LeRoux, Daylor, Poling, Michaels, and Matsko Optometrists will retain your medical records for a minimum of 7 years, as required by law. Under most circumstances, we retain your medical records indefinitely. If destruction of old medical records is ever required for patients that have not returned within 7 years, we would destroy your medical records with patient confidentiality as the utmost priority in that endeavor. Over the past 100 years, we have yet to need to destroy any records.

For more information about our Privacy Practices, please contact:

Family Vision Care of Richmond
Drs. LeRoux, Daylor, Poling, Michaels & Matsko-Optometrists
Privacy Official: Jeffrey Michaels
4114 Innslake Drive
Glen Allen, Virginia 23060
(804) 217-9883 phone
(804) 217-9065 fax

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(877) 696-6775 (toll-free)

********Acknowledgement of Receipt of Privacy Policies********

I acknowledge that I received a copy of the Notices of Privacy Practices for this office.

Signature _____ **Date**_____

Family Vision Care of Richmond

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Drs. LeRoux, Daylor, Poling, Michaels & Matsko

Optometrists

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Glen Allen, VA 23060

804-217-9883

804-217-9065

fvcor.com

Release of Medical Records

First Name _____ Last Name _____ Date of Birth _____

I hereby authorize the release of Medical Records:

- To Family Vision Care of Richmond (From another Doctor/Office)
- From Family Vision Care of Richmond (To another Doctor/Office)

Doctor/Office Name _____

Doctor/Office Address _____

Doctor/Office Phone Number _____ Doctor/Office Fax Number _____

_____ _____

Client Signature Date