PATIENT REGISTRATION

Today's Date: _______/_______/______

PATIENT INFORMATION

Last Name________________________First Name_____________________Preferred Name:____________________

Date of Birth_____/_____/_____Age_____Gender ☐ Female ☐ Male ☐ __________Preferred Pronoun_____________

Email____

Street___________________________________City_____________________State________Zip______________

Phone: Home_________________________Cell________________________Work___________________________

Occupation__________________________________Employer____

Are there specific vision requirements or restrictions for your job? __________________________________

Do you have a specialized driver's license? ☐ CDL ☐ Pilot ☐ Motorcycle ☐ Other: _________________________

Emergency Contact Name________________________________Phone_________-__________________________

SharpeVision has my permission to leave messages with me or my family regarding my appointments: ☐ Yes ☐ No

Please list the name of any person(s) with whom you authorize SharpeVision to discuss your care:

____

Please select the information we can discuss with above person(s): ☐ Personal ☐ Medical ☐ Financial

REGARDING TODAY'S APPOINTMENT

Did your eye doctor refer you? ☐ Yes ☐ No

Eye Doctor Name/Location: ____

What specifically would you like to address today? ____

What questions do you have for your appointment? ____

____

What activities, sports, or hobbies would you enjoy more without depending on glasses/contacts (e.g. skiing, movies, etc.)?

____

____

Were you referred to us by one of our previous patients? ☐ YES ☐ NO NAME: _________________________

EYE HEALTH HISTORY

How are you managing your vision?

☐ **Glasses** How old is the prescription in your glasses? ________________________________

☐ **Contacts** **Type:** ☐ Soft ☐ Gas Perm ☐ Toric ☐ Do not use **Do you sleep in contacts**? ☐ YES ☐ NO

How many years have you worn contacts?___________When did you last wear contacts?_____________☐ NOW

Have you experienced any of these eye/health issues in the past 12 months?

☐ Stinging	☐ Burning/Itching	☐ Glare	☐ Double Vision
☐ Dryness	☐ Redness	☐ Light Sensitivity	☐ Trouble with Night Vision
☐ Excess Tearing	☐ Grittiness	☐ Occasional Blurred Vision	☐ Decreased Contact Lens Wearing Time

Have you ever been diagnosed with or treated for:

☐ Blindness	☐ Strabismus (crossed eyes)	☐ Flashes or Floaters	☐ Stye or Chalazion
☐ Amblyopia (lazy eye)	☐ Retinal Disease	☐ Keratoconus	☐ Iritis
☐ Cataracts	☐ Macular Degeneration	☐ Corneal Disease	☐ Diabetes / ☐ Insulin dependent
☐ Glaucoma	☐ Retinal Detachment	☐ Infection of Eye or Lid	☐ HSV/HZV

If you checked any of the previous diagnosis options, please describe:__________________________________

____

Have you ever had any surgery, injury, or laser treatment to the eye? ☐ YES ☐ NO When:______________

If yes, please elaborate:____

MEDICAL HISTORY

Do you currently, or have you ever had any problems in the following areas?

CONSTITUTIONAL
- ☐ Fever, Weight Loss/Gain

INTEGUMENTARY
- ☐ Skin

NEUROLOGICAL
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures

ENDOCRINE
- ☐ Thyroid/Other Glands

PSYCHIATRIC
- ☐ Depression
- ☐ Other _______

RESPIRATORY
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema

EARS, NOSE, MOUTH, THROAT
- ☐ Allergies/Hay Fever
- ☐ Sinus Congestion
- ☐ Runny Nose
- ☐ Post-Nasal Drip
- ☐ Chronic Cough
- ☐ Dry Throat/Mouth

VASCULAR/CARDIOVASCULAR
- ☐ Diabetes
- ☐ Heart Pain
- ☐ High Blood Pressure
- ☐ Vascular Disease

GENITOURINARY
- ☐ Genitals/Kidney/Bladder

GASTROINTESTINAL
- ☐ Diarrhea
- ☐ Constipation

BONES/ JOINTS/ MUSCLES
- ☐ Rheumatoid Arthritis
- ☐ Muscle Pain
- ☐ Joint pain

LYMPHATIC/ HEMATOLOGIC
- ☐ Anemia
- ☐ Bleeding Problems

ALLERGIC/IMMUNOLOGIC
- ☐ Autoimmune Disease

Please specify ____________
- ☐ HIV

If you checked any of the above or have a condition not listed, please explain:_______________________________________

____

Do you have any allergies to medications? ☐ YES ☐ NO If yes, please list:_____________________________

____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

☐ NONE ____

____

Have you ever taken Accutane (generic Isotretinoin)? ☐ YES ☐ NO If yes, please specify when _______________

Are you pregnant or nursing? ☐ YES ☐ NO If yes, please specify ______________________

Primary Care Physician/ Location___________________________________Date of last physical exam ______________

Eye Doctor/ Location____Date of last eye exam _________________

FAMILY AND SOCIAL HISTORY

Family history

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

☐ Blindness	☐ Keratoconus	☐ Multiple Sclerosis	☐ Heart Disease
☐ Amblyopia (lazy eye)	☐ Retinal Detachment	☐ Arthritis	☐ High Blood Pressure
☐ Cataracts	☐ Retinal Disease	☐ Cancer	☐ Kidney Disease
☐ Glaucoma	☐ Stroke	☐ Diabetes	☐ Lupus
☐ Strabismus (crossed eye)	☐ Allergic Disorders	☐ Cholesterol, Elevated	☐ Thyroid Disease
☐ Macular Degeneration	☐ Migraines		

If you checked any of the above, please list the affected individual's relationship to you:___________________________

____

Social History

This information is kept strictly confidential. If you would prefer to discuss this portion directly with the doctor, please check box: ☐

Do you use tobacco products? ☐ YES ☐ NO If yes, type/amount/how long?_____________________________

Do you use alcohol? ☐ YES ☐ NO If yes, type/amount/how long?_____________________________

SIGNATURE OF PATIENT____DATE ___________________

I hereby affirm all information on this form to be correct to the best of my knowledge.

NOTICE OF PRIVACY PRACTICES

Effective March 26, 2013 the HIPAA/HITECH Final Omnibus Rule adopted modifications, which require certain additional statements in this document regarding uses and disclosures that require authorization. This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 1, 2013 and will remain in effect until we replace it. We may change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We may make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. We will post a copy of our notice in our office and on our website: www.sharpe-vision.com. The effective date of the Notice is provided above.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact the Privacy Officer whose contact information is provided at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to another healthcare provider providing treatment to you, or if we refer you to another healthcare provider.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information with our billing department, your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment. For example, we may give information about a procedure that you had to your insurance company so it will pay us or reimburse you for your procedure.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, and licensing or credentialing activities.

Individuals Involved in Your Care or Payment of Your Care: We may share with a family member, friend or other person identified by you, your health information that is directly related to that person's involvement in your care or payment for your care, or to notify such individuals of your location or general condition, but only if you agree that we may do so, or, based on our professional judgment, we determine that you would not object to the disclosure. We will also use our professional judgment and our experience in allowing a person to pick up health information on your behalf.

Business Associates: There are some services provided in our organization through contracts with business associates. When these services are contracted, we may disclose your PHI to our business associate so that they can perform the job we've asked them to do. To protect your PHI, however, we require all business associates to appropriately safeguard your information.

Use and Disclosure of Health Information Required by Law: We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by state worker's compensation laws.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Contacting You: We may use and disclose your health information to contact you about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, email, or mail. We may leave you messages at the telephone number you give us.

Health-Related Services: We may use and disclose your health information to send you information by mail or email about our health-related products and services available to you, general health news and information, and offers available only to our patients. We will tell you how to cancel these communications, however.

Your Authorization: As explained in this Notice, we may use and disclose your health information for treatment, payment, or health care operations; in certain situations if you agree or object; as required by law; to contact you; and to send you health-related information, but we cannot use or disclose your health information for any other reason without your written authorization. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures already made with your authorization while it was in effect.

PATIENT RIGHTS

Right to See and Copy Your Health Information: You have the right to see or get copies of your health information, with limited exceptions. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of our denial. You must make a written request us to access your health information. Your written request must be signed and dated. We may charge you a fee for expenses such as copies, staff time, and postage. Instead of providing you with a copy of your health information, we may prepare a summary or an explanation of your health information for a fee, if you agree in advance to the form and fee of the summary or explanation.

Right to Accounting of Disclosures of Your Health Information: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, and healthcare operations, and certain other activities for the last 6 years, but not before April 1, 2014. If you request this accounting more than once in a 12-month period, we may charge you a fee for responding to these additional requests. You must submit a written request that is signed and dated. Your request must be submitted to the Privacy Officer whose contact information is at the end of this notice.

Right to Request Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. You must submit a written request that is signed and dated to the Privacy Officer whose contact information is at the end of this notice. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in certain situations, such as to provide you with emergency treatment).

Right to Request Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. For example, you can ask that we only contact you at work, or only by mail. You must make your request in writing and your request must be signed and dated. Your request must specify the ways in which you wish to be contacted. You do not need to tell us the reason for your request. Your request must be submitted to the Privacy Officer whose contact information is at the end of this notice.

Right to Request Amendment: You have the right to request that we amend your health information. You must submit a written request that is signed and dated. Your request must explain why your health information should be amended. Your request must be submitted to the Privacy Officer whose information is at the end of this notice. If we deny your request, we will respond to you in writing with the reason we cannot grant your request and explain your options.

Right to Written Notice: If you receive this Notice on our website or by email, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. Or, if you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

PRIVACY OFFICER

Should you wish to contact the Privacy Officer, you may do so at the address and telephone number below.

Privacy Officer
11005 Burnet Rd. Suite 120
Austin, TX 78758
Telephone: (512) 596-2020

PATIENT ACKNOWLEDGMENT

Thank you very much for reviewing how we are carefully using your health information. If you have any questions, please feel free to ask us. If you don't have any further questions, we would really appreciate it if you would acknowledge that you have received a copy of our policy by signing this form and returning it to us. We look forward to seeing you soon.

Printed Name: ______________________________

Patient Signature: __________________________ Date __________