MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Date of **birth**: _____ Date of **last eye exam**: _____

Are you pregnant or is there any possibility you could be pregnant? ☐ Yes ☐ No

List any **medications** you currently take (prescription and over-the-counter) **including dosage and frequency**:

_____

_____

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, tonsillectomy, appendectomy):

_____

_____

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

	Yes	No	Explanation of Problem
EYES (Glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL/CONSTITUTIONAL			
Fever			
Weight loss			
Other			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			

Name: _____ Date: _____

Date of **birth**: _____

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

	Yes	No	Explanation of Problem
CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (Cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, Lupus, Sjogrens, etc.)			

FAMILY HISTORY M=mother F=father S=sibling GP=grandparent

DISEASE	Yes	No	RELATIONSHIP TO PATIENT
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation: _____

Education (high school, vocational school, college degree): _____

Marital Status (married, divorced, single, widowed): _____

Living arrangements: _____

Do you drive? ☐ Yes ☐ No

Do you have visual difficulty when driving? ☐ Yes ☐ No

Do you have problems with night vision? ☐ Yes ☐ No

Have you ever tried to wear contact lenses? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No

If YES, how long have you worn contact lenses?

Do you currently wear glasses? ☐ Yes ☐ No

If YES, how long have you had your current prescription?

Do you drink alcohol? ☐ Yes ☐ No If "YES": occcasional 1 per day 2-3 per day 4+ per day

Do you smoke? ☐ Yes ☐ No If "YES": occasional 1/2 pack/day 1 pack/day 1+ pack/day

Do you have a living will/advance directive? ☐ Yes ☐ No *Information available at front desk*

Have you ever had a blood transfusion? ☐ Yes ☐ No

Have you recenly traveled outside the US? ☐ Yes ☐ No If yes, Location: _____

History reviewed. ☐ No changes ☐ Additions as noted above

Physician's signature: _____ Date: _____

EAST RIDGE EYE CENTER

TODAYS DATE:

PATIENT FULL NAME:	**DATE OF BIRTH**: **SOCIAL SECURITY NUMBER:**
BEST CONTACT PHONE # :	**MAILING ADDRESS**:
EMAIL ADDRESS: **PREFERRED LANGUAGE:**	**MARITAL STATUS**: ***SPOUSE NAME***: ***SPOUSE PHONE NUMBER***:
RACE: ***THIS IS IMPORTANT AS SOME RACES ARE MORE AT RISK OF DEVELOPING CERTAIN EYE DISEASES.*** **IF PT IS A MINOR**: OTHER PARENT/GUARDIAN NAME: OTHER PARENT/GUARDIAN PHONE:	**RESPONSIBLE PARTY**: ***ADDRESS***: ***PHONE:*** ***IS THIS PERSON THE PATIENT'S LEGAL REPRESENTATIVE? Y/N?***

EMERGENCY CONTACT (*SOMEONE AT DIFFERENT ADDRESS)*

NAME:	**RELATIONSHIP**:
PHONE NUMBER:	**ADDRESS**:

EMPLOYER INFORMATION

PLEASE CIRCLE ONE: EMPLOYEED RETIRED DISABLED OTHER

NAME/COMPANY:	**PHONE NUMBER**: ;
ADDRESS :	DO WE HAVE PERMISSION TO VERIFY YOUR EMPLOYMENT?_____ *IF YES PLEASE SIGN*

INSURANCE INFORMATION

PRIMARY INSURANCE:	**ID NUMBER**:
PHONE NUMBER:	**GROUP NUMBER**:
SUSCRIBER:	
SECONDARY INSURANCE:	**ID NUMBER**:
PHONE NUMBER:	**GROUP NUMBER**:

PRIMARY CARE PROVIDER/OTHER

IF A REFERRAL IS NOT ON FILE AND IS REQUIRED BY YOUR INSURANCE – YOU WILL NEED TO RESCHEDULE OR PAY FULL SERVICE AMOUNTS.

NAME/OFFICE:	**PHONE NUMBER**:
NAME/OFFICE:	**PHONE NUMBER**:

PHARMACY:

NAME:	**PHONE NUMBER**:
ADDRESS:	

EAST RIDGE
EYE CENTER
& OPTICAL DISPENSARY

EyeMD
OPHTHALMOLOGY

www.eastridgeeyecenter.com

Jim Richmond, M.D.
Carey Dozier, M.D.

Cataract Surgery

Laser Surgery

Glaucoma Treatment
& Evaluation

Diabetic Eye Disease

Therapeutic Botox

Dry Eye Treatment
& Evaluation

Eye Lid Surgery
Blepharoplasty

Complete Eye Exams
for Adults & Children

Laser for Glaucoma
& Diabetes

Dilated Eye Exam

We do not use or recommend dilation reversal drops.

In order to perform a complete ocular examination, your eyes will be dilated. Dilation is accomplished by placing drops in your eyes.

Dilation will make the pupils large so the doctor can visualize the optic nerves and peripheral retina more clearly.

Dilation will last approximately 6-8 hours on an adult, and up to 24 hours on a child dependent upon the drops needed and used.

Your eyes will be more sensitive to bright light and your near vision will be blurred. Sunglasses are recommended. The office will supply disposable sunglasses for your convenience.

If you need an excuse for work/school, one will be provided to you upon request. The excuse will state the time you were here and will release you to return to work/school the same day.

Please direct any questions to the technician that works with you during your appointment.

Thank you for choosing East Ridge Eye Center for the care of your eyes.

_____
Patient Signature

_____
Date

932 SPRING CREEK ROAD • CHATTANOOGA, TN 37412 • 423.894.1453 • FAX 423.899.8022

EAST RIDGE
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Eye Lid Surgery Blepharoplasty

Complete Eye Exams for Adults & Children

Laser for Glaucoma & Diabetes

EMPLOYMENT VERIFICATION RELEASE

DATE: _____

I, _____, (patient name) give permission for East Ridge Eye Center to verify the employment information with both current and previous employers for the insurance subscriber/holder listed below.

Insurance Subscriber/Holder Name: _____

Insurance Subscriber/Holder Date of Birth: _____

Insurance Subscriber/Holder Current Employer:

Name: _____

Address: _____

_____

Phone: _____

Contact Person: _____

Dates of employment: _____

Insurance Subscriber/Holder Previous Employer:

Name: _____

Address: _____

_____

Phone: _____

Contact Person: _____

Dates of employment: _____

_____
Patient Signature

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DIPLOMATES, AMERICAN BOARD OF OPHTHALMOLOGY

Cataract Surgery

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Refractive Surgery

Eye Lid Surgery Blepharoplasty

Complete Eye Exams for Adults & Children

Laser for Glaucoma & Diabetes

Acknowledgment of Receipts of Notice of Privacy Practices

Patient Name: _____

I acknowledge that I have received a copy of East Ridge Eye Center's Notice of Privacy Practices, including the addendum dated 09/20/2013 (pages 1-3). This Notice describes how East Ridge Eye Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Relationship to Patient

932 SPRING CREEK ROAD • CHATTANOOGA, TN 37412 • 423.894.1453 • FAX 423.899.8022 • www.eastridgeeyecenter.com

East Ridge Eye Center

Notice of Privacy Practices for Protected Health Information

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!

Our office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for treatment purposes are:

- A nurse or medical assistant obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines he will need to consult with another specialist in the area. He will share the information with such specialist and obtain his/her input.

Example of use of your health information for payment purposes:

- We submit requests for payment to your health insurance company. The health insurance company or business associate helping us obtain payment requests information from us regarding your medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

We may obtain services from business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the doctor's office. You have the following rights with respect to your Protected Health Information

1. Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office—we are not required to grant the request but we will comply with any request granted;
2. Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
3. Right to inspect and copy your health record and billing record (a fee will apply)—you may exercise this right by delivering the request in writing to our office; appeal a denial of access to your protected health information except in certain circumstances;
4. Right to request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office. (The physician or other health care provider is not required to make such amendments); you may file a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
5. Right to receive an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
6. Right to confidential communication by requesting that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office, and,

If you want to exercise any of the above rights, please contact **Teri Reneau, 423-894-1453, 932 Spring Creek Road, Chattanooga, TN 37412**, by telephone or in writing, during normal hours. She will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.
- Accommodate your request for an accounting of disclosures.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact **Teri Reneau, Office Manager, 423-894-1453.**

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to **Teri Reneau.** You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address is **200 Independence Avenue, SW, Washington, D.C. 20201** and e-mail address is **www.hhs.gov.**

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

The Following is a List of Other Uses and Disclosures Allowed by the Privacy Rule

Patient Contact
We may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you. We may contact you as part of a fund raising effort.
Notification – Opportunity to Agree or Object
If you are present and able and do not object, or if you are not present, able, or in an emergency using our professional judgment we may:
Disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care. This will allow them to pick up a filled prescription, etc.
Use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.
We may use and disclose your protected health information to assist in disaster relief efforts.

Notification - Opportunity to Agree or Object Not Required

PUBLIC HEALTH ACTIVITIES
Controlling Disease - As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
Child Abuse & Neglect - We may disclose protected health information to public authorities as allowed by law to report child abuse or neglect.
Food and Drug Administration (FDA) - We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.
Provider Note: Health care providers working for an Industry performing medical surveillance or evaluating whether the individual has a work related injury or illness may disclose PHI pertaining to the work related injury or illness to the employer if the employer needs the findings in order to comply with OSHA regulations.

VICTIMS OF ABUSE , NEGLECT, OR DOMESTIC VIOLENCE
We can disclose protected health information to governmental authorities to the extent the disclosure is authorized by statute or regulation and in the exercise of professional judgment the doctor believes the disclosure is necessary to prevent serious harm to the individual or other potential victim.
OVERSIGHT AGENCIES
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities to include audits, civil, administrative or criminal investigations: inspections; licensures or disciplinary actions, and for similar reasons related to the administration of healthcare.
JUDICIAL/ADMINISTRATIVE PROCEEDINGS
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, or as directed by a proper court order or administrative tribunal, provided that only the protected health information released is expressly authorized by such order, or in response to a subpoena, discovery request or other lawful process.
LAW ENFORCEMENT
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by court order, including laws that require reporting of certain types of wounds or other physical injury.
CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS
We may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.
ORGAN PROCUREMENT ORGANIZATIONS
Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs, eyes, or tissue for the purpose of donation and transplant.
RESEARCH
We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
THREAT TO HEALTH AND SAFETY
To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.
FOR SPECIALIZED GOVERNMENTAL FUNCTIONS
We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.
CORRECTIONAL INSTITUTIONS
If you are an inmate of a correctional institution, we may disclose to the institution or it's agents the protected health information necessary for your health and the health and safety of other individuals.
WORKERS COMPENSATION
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Other Uses and Disclosures
- Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization which you may revoke except to the extent information or action has already been taken.

Website
- If we maintain a website that provides information about our entity, this Notice will be on the website. **Effective Date: N/A**

Addendum to Notice of Privacy Practices for PH

Dear Patient,

We are advising you of some new changes to the HIPPA Privacy Notice that Easy Ridge Eye Center provided at the time of your initial visit.

The Notice has been revised to reflect the following material changes:

- You now have the right to be notified following a breach of unsecured Protected Health Information.
- You now have the right to request an electronic copy of your Protected Health Information in a form or format as mutually agreed to by you and us. (We currently do not use electronic medical records, but may do so in the future.)
- Easy Ridge Eye Center does not sell or use your Protected Health Information for marketing or fundraising purposes. However, the Notice now includes a required statement that uses and disclosures of Protected Health Information for marketing purposes, and disclosures that constitute a sale of Protected Health Information would require your prior authorization.
- You now have the right to request amendments to records when errors are identified upon written request.
- You now have the right to pay out of pocket for services and request that the practice DOES NOT disclose the information.

If you wish to view a copy of our revised Notice, you can submit a written request to:

East Ridge Eye Center
932 Spring Creek Road
Chattanooga, TN 37412

Please be sure to include the following information in your request:

- Full name
- Address
- Phone number

Thank you for your business and placing your trust in East Ridge Eye Center.

Sincerely,

James P. Richmond, Jr. MD
President of East Ridge Eye Center