Auburn Vision Associates

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Name _____ Date of Birth _____ Age _____ Gender: Male / Female
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell/Work Phone _____ Occupation_____

Last Eye Exam _____ Last Physical Exam _____ Primary Care Doctor's Name:_____
Primary Insurance/Vision Benefits: _____ Medical Insurance: _____
Eye Drops (Prescription or OTC): _____
Medications (Prescription or OTC): _____
Allergies: _____

Medical & Ocular History

Please mark all that apply:

	Self	Relative		Self	Relative
Endocrine (Diabetes)	____	____	Glaucoma	____	____
Respiratory	____	____	Retinal Detachment	____	____
Cardiovascular	____	____	Macular Degeneration	____	____
Gastrointestinal	____	____	Cataract	____	____
Musculoskeletal	____	____	Eye Injury/Surgery	____	____
Ear, Nose, Throat	____	____	Floaters and/or Spots	____	____
Neurological	____	____	Flashes of light	____	____
Psychological	____	____	Dryness/Burning/Tearing/Itching	____	____
Other	____	____	Other	____	____

Please fill out this section ONLY if you wear Contact Lenses:

What brand of contact lenses do you wear? (If known) _____
How often do you replace your contact lenses? _____
What cleaning solutions do you use? _____
How many hours do you wear your contact lenses? _____ Do you sleep in your lenses? **YES** **NO**

Privacy Practices Acknowledgement

You are free to refer to this notice at any time before you sign this form. The use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also information necessary for you to receive care from another health professional. Similarly, the use and disclosure of your health information for purposes of third-party payment may include: our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; submission of your health information to auditors hired by third-party payers and insurers; other aspects of payment described in the NOTICE. The NOTICE will be updated whenever our privacy practices change. Copies are available in our office. When you sign this consent document, you signify that you agree that we can and will use and disclose your heath information to treat you, to obtain payment for services, and to perform healthcare operations. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment, or healthcare operations, but as described in the NOTICE, we are not obliged to agree to these restrictions.

I have read and understood this document. I consent to the use and disclosure of my health information for purposes of treatment, payment for services, and healthcare operations.

Signature: _____ **Date:** _____