DRUMMOND EYE CLINIC

# PATIENT DEMOGRAPHICS

## PATIENT INFORMATION

PATIENT NAME: _____
LAST FIRST MIDDLE

PREFERRED NAME: _____ GENDER: ☐ Male ☐ Female ☐ Trans Male ☐ Trans Female

PRONOUNS: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Decline to Specify ☐ Other: _____

BILLING ADDRESS: _____
STREET CITY STATE ZIP

HOME PHONE: _____ CELL PHONE: _____

OTHER PHONE: _____ EMAIL ADDRESS: _____

DATE OF BIRTH: _____ SSN: _____ MARITAL STATUS: _____

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICHIAN: _____

EMPLOYER: _____ OCCUPATION: _____

RACE: ☐ American Indian / Alaskan Native ☐ Asian ☐ Black or African American ☐ European ☐ Hispanic
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Decline to Specify ☐ Other: _____

## PARENT/GUARDIAN/SUBSCRIBER (If patient is a minor OR If patient is covered by another's insurance)

NAME: _____RELATIONSHIP TO PATIENT: _____

DATE OF BIRTH: _____ PRIMARY PHONE: _____ OTHER PHONE: _____

INSURED MEMBER'S SSN: _____ INSURED MEMBER'S EMPLOYER: _____

## EMERGENCY CONTACT

NAME: _____RELATIONSHIP TO PATIENT: _____

PRIMARY PHONE: _____ OTHER PHONE: _____

I authorize use of this form on all my insurance submissions. I authorize release of information to all my insurance companies. I understand that **I AM RESPONSIBLE** for paying my bill including any co-pays, co-insurance, or deductible due on the date of service. I authorize payment direct to my doctor, and I permit a copy of this authorization to be used in place of the original. For minor patients, the person accompanying the patient is responsible for the bill. We will provide a copy of the receipt upon request of the guarantor.

**PATIENT / GUARDIAN SIGNATURE:** _____**DATE:** _____

# PATIENT MEDICAL HISTORY

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NAME: _____ DATE: _____

## OCULAR HISTORY

Please answer the following questions about your eye health:

Have you ever been had any **LASIK, RK, PRK** or other **REFRACTIVE SURGERY**? (List surgery below) ☐ YES ☐ NO

Have you ever been diagnosed with **CATARACTS** or had **CATARACT SURGERY**? (List surgery below) ☐ YES ☐ NO

Have you ever been diagnosed with **GLAUCOMA**? (List any eye drops you are taking below) ☐ YES ☐ NO

Have you ever been diagnosed with **MACULAR DEGENERATION (AMD)**? (If receiving injections list below) ☐ YES ☐ NO

Have you ever been diagnosed with **DRY EYE SYNDROME**? (List any eye drops you are taking below) ☐ YES ☐ NO

Have you ever been diagnosed with **DIABETES**? ☐ YES ☐ NO

If you are diabetic: ☐ Type I ☐ Type II Last blood sugar: _____ A1c: _____

Which doctor do you see for your diabetes? _____

Have you ever been diagnosed with **ANY OTHER EYE DISEASE or CONDITIONS**? ☐ YES ☐ NO

List other eye conditions: _____

List any eye surgeries, which eye, and approximately when you had the surgery (for eye injections, list most recent one):

_____

List any eye drops you take and how many times per day / when you take them:

_____

_____

## MEDICAL HISTORY

List any other surgeries you have had the date and approximately when you had the surgery:

_____

List any other medications you are taking including vitamins and over the counter meds, and how often you take them:

_____

_____

_____

_____

*Please use back side of page to list more medications or have the front desk make a copy of your medication list.*

List any medications you are allergic to: _____

Have you had this year's flu vaccine? ☐ YES ☐ NO

Have you had the pneumonia vaccine? ☐ YES ☐ NO

Have you had the COVID-19 vaccine? ☐ YES ☐ NO

Are you allergic to Latex? ☐ YES ☐ NO

Do you smoke or use tobacco? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO

If yes, list which one: _____

# PATIENT MEDICAL HISTORY

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## REVIEW OF SYSTEMS

Please check the box for any of the below medical conditions you have or are taking medications for:

CARDIOVASCULAR
- ☐ A-Fib
- ☐ High Cholesterol
- ☐ Hypertension (High Blood Pressure)
- ☐ Heart Stent
- ☐ Heart Valve Replacement
- ☐ Stroke
- ☐ Other: _____

CONSTITUTIONAL
- ☐ Dizziness
- ☐ Unexplained Weight Loss
- ☐ Other: _____

ENDOCRINE
- ☐ Crohn's
- ☐ Diabetes (see ocular history)
- ☐ Thyroid Disorder
- ☐ Hormonal Disorder
- ☐ Other: _____

GASTROINTESTINAL
- ☐ Acid-reflux
- ☐ Colon / Stomach Cancer
- ☐ Gastrointestinal Disorder
- ☐ Hepatitis
- ☐ Ulcer
- ☐ Other: _____

GENITOURINARY
- ☐ Prostate Cancer
- ☐ STI – Viral, Herpetic, Chlamydia, Syphilis
- ☐ Other: _____

HEMATOLOGIC/LYMPHATIC
- ☐ Anemia
- ☐ Leukemia
- ☐ Temporal Arteritis
- ☐ Other: _____

IMMUNOLOGIC
- ☐ AIDS / HIV Positive
- ☐ Herpes Zoster / Shingles
- ☐ Sjogren's Syndrome
- ☐ Other: _____

INTEGUMENTARY (SKIN)
- ☐ Eczema
- ☐ Lupus
- ☐ Ocular Rosacea / Blepharitis
- ☐ Psoriasis
- ☐ Other: _____

MUSCULOSKELETAL
- ☐ Ankylosing Spondylitis
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ Other: _____

NEUROLOGICAL
- ☐ Bell's Palsy
- ☐ Dyslexia
- ☐ Epilepsy
- ☐ Headaches
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Other: _____

PSYCHIATRIC
- ☐ ADD / ADHD
- ☐ Alzheimer's Disease
- ☐ Anxiety Disorder
- ☐ Dementia
- ☐ Depression
- ☐ Learning / Development Disorder
- ☐ Schizophrenia
- ☐ Other: _____

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Lung Cancer
- ☐ Pneumonia
- ☐ Other: _____

## FAMILY HISTORY

Please check the box for any of the below medical conditions that any BLOOD RELATIVES in your family have had, and list the relation of the relative who had the condition (example: father, aunt, maternal grandmother, etc.):

- ☐ Diabetes: _____
- ☐ High Blood Pressure: _____
- ☐ High Cholesterol: _____
- ☐ Amblyopia (Lazy Eye): _____
- ☐ Blindness: _____
- ☐ Cataract: _____
- ☐ Glaucoma: _____
- ☐ Macular Degeneration: _____
- ☐ Retinal Detachment: _____
- ☐ Other Eye Disease (List condition): _____

_____

_____

# NOTICE OF PRIVACY PRACTICES

DRUMMOND EYE CLINIC

## ACKNOWLEDGEMENT AND CONSENT OF PRIVACY POLICIES

The Notice of Privacy Practices explains in detail how we may use and share your health records. **Please read it.**

- We will use and share your health records to treat you.
- We will use and share your health records to bill for the services we provide.
- We will use and share your health records to operate the business.
- We will use and share your health records as required by law.

The Notice of Privacy Practices also explains in detail the following rights you have with respect to your health records.

- You have the right to look at and receive a copy of your health records.
- You have the right to receive a list of whom we have given your health records to.
- You have the right to ask us to correct a mistake in your health records.
- You have the right to ask that we not use or share your health records.
- You have the right to ask us to change the way we contact you.

Oklahoma law requires that we advise you that **the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS).** It also may include mental health or other sensitive information.

If you would like the physicians and staff of Drummond Eye Clinic to be able to discuss your health record with any other individuals (including diagnoses, treatments, dates and times of surgeries, etc.) you must give permission for them to access your Protected Health Information (PHI).

**PLEASE LIST ANY INDIVIDUALS YOU WOULD LIKE TO HAVE ACCESS TO YOUR HEALTH RECORD BELOW:**

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

### ACKNOWLEDGEMENT

I have received and reviewed a copy of the Drummond Eye Clinic's Notice of Privacy Practices.

PATIENT / LEGAL REPRESENTATIVE SIGNATURE: _____ DATE: _____

Capacity of Legal Representative (if applicable): _____

May be requested to provide verification of representative status.

### CONSENT

I consent to the use and sharing of my health records for treatment, payment and operation purposes as described in the Notice of Privacy Practices. I understand that if I do not consent, you cannot provide services to me.

I give permission to the physicians and staff of Drummond Eye Clinic to share Protected Health Information (PHI) with the individuals listed above.

PATIENT / LEGAL REPRESENTATIVE SIGNATURE: _____ DATE: _____

Capacity of Legal Representative (if applicable): _____

May be requested to provide verification of representative status.