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 PHYSICIAN: _____

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

If yes, list which one: _____

Are you allergic to Latex? ☐ YES ☐ NO

Do you smoke or use tobacco? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO

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.

NOTICE OF PRIVACY PRACTICES
Drummond Eye Clinic

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.

Physicians are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide you with notice of our legal duties and privacy practices with respect to PHI. PHI is information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. This Notice of Privacy Practices ("Notice") describes how we may use and disclose PHI to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to your PHI. We are required to provide this notice to you by the Health Insurance Portability and Accountability Act ("HIPAA").

The Drummond Eye Clinic is required to follow the terms of this Notice. We will not use or disclose your PHI without your written authorization, except as described or otherwise permitted by this Notice. We reserve the right to change our practices and this Notice and the make the new Notice effective for all PHI we maintain. Upon request, we will provide any revised Notice to you.

Examples of How We Use and Disclose Protected Health Information about You.

The following categories describe different ways that we use and disclose your protected health information. We have provided you with examples in certain categories; however, not every use or disclosure in a category will be listed.

Treatment. Your health information may be used by our staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of ocular tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by our staff.

Payment. Your health information may be used to seek payment from your health care plan, from other sources of coverage such as automobile insurers, or from credit card companies that you may use to pay for services. For example, your health care plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary in certain operational, administrative and quality assurance activities. For example, information concerning the services you receive may be disclosed to business associates if they need to receive this information to provide a service to use and will agree to abide by specific HIPAA rules relating to the protection of health information.

We are permitted to use or disclose your PHI for the following purposes. However, Drummond Eye Clinic may never have reason to make some of these disclosures.

To Communicate with Individuals Involved in Your Care or Payment for Your Care. We may disclose to a family member, other relative, close personal friend or any other person you identify PHI directly relevant to that person's involvement in your care or payment related to your care.
Workers' Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.
Public Health. As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
Law Enforcement. We may disclose your PHI for law enforcement purposes as required by law or in response to a subpoena or court order.
As Required by Law. We will disclose your PHI when required to do so by federal, state, or local law.
Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.
Organ or Tissue Procurement Organizations. Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation or organs for the purpose of tissue donation and transplant.
Notification. We may use or disclose your PHI to notify or assist in notifying a family member, personal representative, or another person responsible for your care, regarding your location and general condition.
To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Veterans. If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.
Victims of Abuse or Neglect. We may disclose PHI about you to a government authority if we reasonably believe you are a victim or abuse or neglect. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else.
Other Uses and Disclosures of PHI. We will obtain your written authorization before using or disclosing your PHI for purposes other than those provided for above (or as otherwise permitted or required by law). You may revoke and authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Obtain a paper copy of the Notice upon request. You may request a copy of our current Notice at any time. Even if you have agreed to receive the Notice electronically, you are still entitles to a paper copy. You may obtain a paper copy form from the Privacy Officer of this Clinic.
Request a restriction on certain uses and disclosures of PHI. You have the right to request additional restrictions on our use or disclosure of your PHI by sending a written request to the Privacy Officer. We are not required to agree to those restrictions. We cannot agree to restrictions of uses or disclosure that are legally required or which are necessary to administer our business.
Inspect and obtain a copy of PHI. In most cases, you have the right to access and copy the PHI that we maintain about you. To inspect or copy your PHI, you must send a written request to the Privacy Officer. We may charge you a fee for the costs of copying, mailing, and supplies that are necessary to fulfill your request. We may deny your request and inspect and copy in certain limited circumstances.
Request an amendment of PHI. If you feel the PHI we maintain about you in incomplete or incorrect, you may request that we amend it. To request an amendment, you must send a written request to the Privacy Officer. You must include a reason that supports your request. In certain cases, we may deny your request for amendment.
Receive an accounting of disclosure of PHI. You have the right to receive an accounting of the disclosures we have made of your PHI after April 14, 2003, for most purposes other than treatment, payment, or health care operations. The right to receive an accounting is subject to certain exceptions, restrictions, and limitations. To request an accounting, you must submit a request in writing to the Privacy Officer. Your request must specify the time period. The time period may not be longer than six years and may not include dates before April 14, 2003.
Request communication of PHI by alternative means or at alternative locations. For instance, you may request that we contact you at a different residence or post office box. To request confidential communication of your PHI, you must submit a request in writing to the Privacy Officer. You request must tell us how or where you would like to be contacted. We will accommodate all reasonable requests.
Where to obtain forms for submitting written requests. You may obtain forms for submitting written requests from this Clinic by contacting:

Privacy Officer
Drummond Eye Clinic
420 South Knoblock
Stillwater, OK 74074

You may also request forms by using the toll-free telephone number 1-877-393-7874.

Incidental Disclosures. Drummond Eye Clinic will make reasonable efforts to avoid incidental disclosures of protected health information. An example of an incidental disclosure is a conversation between a patient and a staff member that may be overhead in the Clinic.
Minors. If you are a minor who has lawfully provided consent for treatment and you wish for Drummond Eye Clinic to treat you as an adult for purposes of access to and disclosure of records related to such treatment, please notify the Privacy Officer.
For More Information or to Report a Problem. If you have questions or would like additional information about Drummond Eye Clinic's privacy practices, you may contact our Privacy Officer. If you believe your rights have been violated, you can file a complaint with the Privacy Officer or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.
Right to Revise Privacy Practices. As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.
Effective Date. This Notice is effective as of April 1, 2003.