

WELCOME TO OUR OFFICE
PARAGOULD EYE CARE
DR. JAMI VEAL

TODAY'S DATE _____

NAME _____	DATE OF BIRTH _____	AGE _____
ADDRESS _____	SSN _____	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
CITY _____	HOME PHONE _____	
STATE _____	WORK PHONE _____	
ZIP _____	CELL PHONE _____	
EMPLOYER / SCHOOL _____	SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
OCCUPATION _____	SPOUSE / PARENT NAME _____	
VISION INSURANCE _____	SPOUSE / PARENT WORK PHONE _____	
MEDICAL INSURANCE _____	MAIN REASON FOR VISIT _____	
MEDICARE / MEDICAID ID # _____	DATE OF YOUR LAST EYE EXAM: _____	
	DO YOU WEAR: GLASSES <input type="checkbox"/> CONTACTS <input type="checkbox"/>	

MAY WE CALL YOU AT WORK? YES NO
MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE? YES NO
MAY WE SHARE INFORMATION REGARDING YOUR CARE WITH YOUR SPOUSE? YES NO

<u>CURRENT MEDICATIONS</u>	<u>FAMILY HISTORY</u>
_____	RELATIONSHIP _____
_____	BLINDNESS <input type="checkbox"/> YES <input type="checkbox"/> NO _____
_____	CATARACTS <input type="checkbox"/> YES <input type="checkbox"/> NO _____
_____	GLAUCOMA <input type="checkbox"/> YES <input type="checkbox"/> NO _____
_____	DIABETES <input type="checkbox"/> YES <input type="checkbox"/> NO _____
_____	HEART DISEASE <input type="checkbox"/> YES <input type="checkbox"/> NO _____
<u>DRUG ALLERGIES</u>	OTHER <input type="checkbox"/> YES <input type="checkbox"/> NO _____

SOCIAL HISTORY

DO YOU USE TOBACCO PRODUCTS? YES NO
IF YES, HOW MUCH? _____

DO YOU DRINK ALCOHOL? YES NO
IF YES, HOW MUCH? _____

ARE YOU PREGNANT? YES NO

ARE YOU BREASTFEEDING? YES NO

HOW DID YOU HEAR ABOUT OUR OFFICE?

FRIEND / RELATIVE - WHO? _____

PREVIOUS PATIENT - WHO? _____

ANOTHER DOCTOR - WHO? _____

CIVIC GROUP / COMMUNITY EVENT

TELEVISION ADVERTISEMENT

NEWSPAPER ADVERTISEMENT

RADIO ADVERTISEMENT

YELLOW PAGES

OTHER _____

MEDICAL HISTORY

PLEASE MARK ANY THAT APPLY TO YOU.

EYES AND VISUAL SYSTEM

- BLURRED VISION _____
- LOSS OF VISION _____
- DISTORTED VISION _____
- DOUBLE VISION _____
- HALOS _____
- TIRED EYES _____
- DRYNESS _____
- REDNESS _____
- ITCHING _____
- BURNING _____
- MUCOUS DISCHARGE _____
- SANDY / GRITTY FEELING _____
- FOREIGN BODY SENSATION _____
- EXCESS TEARING / WATERING _____
- GLARE / LIGHT SENSITIVITY _____
- EYE PAIN OR SORENESS _____
- STIES OR BUMPS ON EYELIDS _____
- CHRONIC INFECTION OF EYE / LID _____
- FLASHES / FLOATERS IN VISION _____
- EYE SURGERIES / INJURIES _____

ENDOCRINE SYSTEM

- DIABETES _____
- THYROID DISORDER _____
- GLANDULAR PROBLEMS _____

CONSTITUTIONAL

- WEIGHT LOSS / GAIN _____
- DIZZINESS / FAINTING _____
- FEVER / CHILLS _____

NEUROLOGICAL

- HEADACHES _____
- MIGRAINES _____
- SEIZURES _____

INTEGUMENTARY / SKIN

- SKIN PROBLEMS _____

EAR, NOSE AND THROAT

- ALLERGIES / HAY FEVER _____
- SINUS CONGESTION _____
- RUNNY NOSE _____
- DRY THROAT / MOUTH _____

RESPIRATORY SYSTEM

- ASTHMA _____
- CHRONIC BRONCHITIS _____
- EMPHYSEMA _____

CARDIOVASCULAR SYSTEM

- HEART PAIN _____
- HIGH BLOOD PRESSURE _____
- VASCULAR DISEASE _____

GASTROINTESTINAL SYSTEM

- ACID REFLUX _____
- STOMACH ULCERS _____
- INTESTINAL DISORDERS _____

GENITOURINARY SYSTEM

- KIDNEY / BLADDER / GENITALS _____

MUSCULOSKELETAL SYSTEM

- OSTEOARTHRITIS _____
- RHEUMATOID ARTHRITIS _____
- MUSCLE PAIN _____
- JOINT PAIN _____

LYMPHATIC / HEMATOLOGIC

- LYMPH NODES PROBLEMS _____
- BLEEDING DISORDERS _____
- HEPATITIS _____
- ANEMIA _____

IMMUNOLOGIC / ALLERGIC

- SEVERE ALLERGIC REACTIONS _____
- IMMUNE DISORDERS _____

PSYCHIATRIC

- PSYCHIATRIC PROBLEMS _____

NOTICE OF PRIVACY POLICY AND INSURANCE INFORMATION PRACTICES OF PARAGOULD EYE CARE

AT PARAGOULD EYE CARE, WE KEEP YOUR PERSONAL INFORMATION CONFIDENTIAL AND SHARE IT ONLY IN A RESPONSIBLE MANNER, AS NECESSARY TO PROVIDE YOU PRIMARY EYE HEALTH CARE AND PRODUCTS YOU PURCHASE FROM US OR TO OFFER YOU ADDITIONAL PRODUCTS AND SERVICES. WE MAINTAIN APPROPRIATE PHYSICAL, ELECTRONIC AND PROCEDURAL SAFEGUARDS TO ENSURE THE CONFIDENTIALITY OF YOUR NONPUBLIC PERSONAL INFORMATION. WE FOLLOW SECURITY STANDARDS AND PROCEDURES TO HELP PREVENT UNAUTHORIZED ACCESS TO PERSONAL INFORMATION. ONLY EMPLOYEES WHO NEED THE INFORMATION WE COLLECT FROM OR ABOUT YOU TO PROVIDE PRODUCTS OR SERVICES TO YOU MAY ACCESS THE INFORMATION. EMPLOYEES ARE REQUIRED TO COMPLY WITH OUR ESTABLISHED POLICIES. THIS OFFICE IS COMPLIANT WITH ALL U.S. H.I.P.A.A. GUIDELINES.

◆ I ACKNOWLEDGE THAT A COPY OF PARAGOULD EYE CARE'S NOTICE OF PRIVACY PRACTICES WAS MADE AVAILABLE TO ME. ◆

PATIENT / GUARDIAN SIGNATURE

DATE