Welcome To Our Office

First Name:_____ Last:_____ Date of Birth:_____

Addr:_____ City:_____ Zip:_____ Hm Phone:_____

Occupation:_____ ☐ Student ☐ Retired Cell Phone:_____

Work Ph:_____

How May We Communicate With You? ☐ Phone ☐ Cell Text ☐ Email Addr:_____@_____

Last Four SS#:_____ Vision Plan:_____ Plan Holder's Name:_____

Primary Medical Plan: ☐ MediCare ☐ Other: _____ Secondary Plan:_____ ☐ Flex Spending Acct.

Reason For Today's Visit? ☐ Routine Visit ☐ Specific Concern:_____

	Yes	No		
Do you wear glasses?	☐	☐	Last Eye Doctor:_____	Last seen: _____
Contacts lenses?	☐	☐	Brand_____	Disinfecting solution used:_____

Eye History:

	Yes	No		Yes	No		Yes	No
Blurred distant vision	☐	☐	Redness	☐	☐	Poor night vision	☐	☐
Blurred reading	☐	☐	Dry eyes	☐	☐	Eye surgery	☐	☐
Blurred computer	☐	☐	Itchy eyes	☐	☐	Past eye disease	☐	☐
Eye irritaion or pain	☐	☐	Light flashes	☐	☐	Past eye injury	☐	☐
Tearing or discharge	☐	☐	Floaters/spots	☐	☐	Contact Lens interest	☐	☐
Double vision	☐	☐	Glare	☐	☐	Laser Correction interest	☐	☐

Medical History:

	Yes	No		Yes	No		Yes	No
High blood pressure	☐	☐	Heart disease	☐	☐	Allergies	☐	☐
Diabetes	☐	☐	Cancer	☐	☐	Medication allergies	☐	☐
Thyroid disease	☐	☐	Arthritis	☐	☐	Smoke tobacco	☐	☐
High cholesterol	☐	☐	Sinus condition	☐	☐	Drink alcohol	☐	☐
Frequent headaches	☐	☐	Skin conditions	☐	☐	Other health conditions	☐	☐

Family History: **Your genetic parents, siblings or children**

	Yes	No		Yes	No
Cataracts	☐	☐	High blood pressure	☐	☐
Glaucoma	☐	☐	Diabetes	☐	☐
Macular disease	☐	☐	Thyroid disease	☐	☐
Color blindness	☐	☐	Cancer	☐	☐

New Patient : Who referred you to us? _____ **Or, How did you find us?** _____

1) I assign my vision and/or medical benefits to this office and accept full responsibilty for any deductibles, copays and/or charges not covered.
2) I do not hold this office responsible for interpreting my benefits and will call my carrier if I have any questions.
3) I know of the Health Insurance Portability and Accountability Act (HIPAA), which explains my rights to and protection of my records.

Signed by patient or legal guardian:_____ Date: _____

PROTECTING YOUR CONFIDENTIAL HEALTH INFORMATION

Notice of Privacy Practices
Dr. Gerald Pittler

Dear Patient:

This notice describes how your health information may be used and disclosed, and your rights to access this information. Federal laws (HIPPA- Health Insurance Portability and Accountability Act) protect your confidential information within our computers and how it is electronically transmitted to other healthcare parties involved in your care.

We will only use or share your health information for the purpose of providing you treatment, in conducting healthcare operations and obtaining payment. We will not use this information for any other purposes unless we have asked for and been given your written consent.

Dr. Gerald Pittler

TO PROVIDE TREATMENT
Our office staff will only use your health information within the office for administrative and clinical procedures related to your healthcare.

TO CONDUCT HEALTH CARE OPERATIONS
Your records may be used during performance evaluations or for training purposes by our staff or student interns in our office. Your insurance provider may view your records during audits for compliance and quality assurance. Regulatory agencies or boards may review your health information for your doctor's certification, licensing or credentialing.

TO OBTAIN PAYMENT
We may include your health information when billing your health insurance or vision plan for services or materials. This will be done by paper or secure electronic mail.

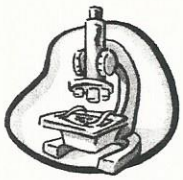
APPOINTMENT REMINDERS
Because we believe in preventative care, we will be notifying you to make regular appointments. We may also contact you or your family regarding treatment options, promotions, product alerts or any information we feel is of interest (unless you tell us otherwise).

LEGAL RESPONSIBILITIES
By law we must report to authorities any evidence of victim abuse, neglect or domestic violence.

FAMILY, FRIENDS AND CAREGIVERS
With you consent, we may share your information with those who assist in your care, such as, in giving treatments or medications, or help in paying your medical bills.

PUBLIC HEALTH AND NATIONAL SECURITY
We may be required to disclose to Federal or military authorities health information necessary to investigate matters of public safety or national security. Prevention of an epidemic, recalling drugs, solutions or contact lenses due to ill-side effects are examples of why this may be necessary.

MEDICAL RESEARCH
Advancing medical knowledge often involves learning from the study of prior medical histories. Your records may be used in a research study that observes ethical guidelines and approval of an Institutional Review Board.



FOR LAW ENFORCMENT
As permitted or required by State or Federal laws, we may be compelled to release your health records for legal purposes.

AUTHORIZATION TO USE OR DISCLOSE
Other than what is stated above or where laws require us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

PATIENT RIGHTS
- ✓ *You have the right to restrict certain disclosures and uses of your health information.*
- ✓ *You have the right to choose how we communicate with you.*
- ✓ *You have the right to read and copy your records.*
- ✓ *You have the right to know how and where we used your health information if other than for treatment, billing for payment or health operations.*
- ✓ *You have the right to obtain a copy of our* ***Notice of Privacy Practices.***

PATIENT ACKNOWLEDGEMENT
After you have acknowledged this document's content, or received a copy to read later, you will be asked to sign our ***Notice of Privacy Practices Log*** *attesting to your being informed as to how this office will protect and may use your health information.*