Welcome to Vista EyeCare
Isabel A Cruz OD

First name : _____
Last name: _____
Address:_____
City: _____ Zip Code:_____
Tel: _____Type: Home/Work/Cell
Email: _____
Date of Birth: _____Age :_____ Sex: M F
Height:_____ Weight :_____lbs

Circle Your Vision Insurance

Always Care EyeMed Superior VSP Spectera None

Medicaid/Plan: _____

Member ID: _____

Insured SSN: _____

Medical Insurance Information

Medical Insurance:_____ PPO/HMO/Medicare
Member ID:_____
Group:_____
Policy holder if name is different:
_____
Policy Holder DOB: _____
SSN: _____
Relationship to patient: _____
Insurance provider phone number: _____

Ocular History:

Purpose of today's visit:
☐Annual visit ☐Headaches ☐Blurry vision
☐Red eye ☐Burning ☐Infection ☐Double vision
☐Itchiness ☐Dryness ☐Night vision difficulty
☐Flash of light ☐Eye pain
☐Floaters/spots in vision ☐Tearing
☐Grittiness ☐Update contact lenses
☐Diabetes ☐Glaucoma

When was your last eye exam?
_____
Do you wear contacts? Y N Brand: _____
Hours of computer usage per day: _____
Do you wear glasses? Y N lost or broken
Have you been diagnosed with the following?
☐Cataracts ☐Iritis/Uveitis
☐Bell's Palsy ☐Dry eye
☐Macular degeneration
☐Eye turn ☐Retinal detachment
☐Glaucoma ☐Retinal defect/hole/tear ☐Injury
☐Other eye diseases

Has anyone in your family been diagnosed with the following?
If yes, who? _____
☐Cataracts ☐Lazy eye
☐Eye turn ☐Macular degeneration
☐Glaucoma ☐Retinal detachment
☐Iritis/uveitis ☐Other eye diseases
☐Diabetes ☐High blood pressure

Who can we thank for your referral to our office?
_____
Current Medications and Dose (include OTC & supplements):
_____
_____
_____
_____
_____
Allergies:_____
_____
List any prior eye surgeries and dates if known (e.g. Lasik):
_____
_____
_____
Are you pregnant or nursing? N Y
Do you use cigarettes? N Y if so, how often? _____
Do you drink alcohol? N Y if so, how often? _____

Medical History:

Have you ever been diagnosed or treated for any of the following health problems? (if yes include date, otherwise, circle no)

Allergies	No Yes Date_____
Arthritis	No Yes Date_____
Asthma	No Yes Date_____
Cancer	No Yes Date_____
Cholesterol	No Yes Date_____
Diabetes	No Yes Date_____
Digestive/Gastric	No Yes Date_____
Ears/Nose/Throat	No Yes Date_____
Endocrine	No Yes Date_____
Fatigue	No Yes Date_____
Heart disease	No Yes Date_____
High blood pressure	No Yes Date_____
HIV/AIDS	No Yes Date_____
Integumentary(skin disease)	No Yes Date_____
Kidney	No Yes Date_____
Muscle or Bone	No Yes Date_____
Neurological/ Headaches	No Yes Date_____
Psychological	No Yes Date_____
Respiratory	No Yes Date_____
Sinus	No Yes Date_____
Stroke/Seizures	No Yes Date_____
Throat infections	No Yes Date_____
Thyroid	No Yes Date_____

Have you received a COVID vaccine? No Yes Date _____

List any medical surgeries:
_____
_____

Are you interested in LASIK? Yes No

Occupation:_____

Notice of Privacy Practices Patient Acknowledgement

I have received this practice's notice of privacy practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The notice includes:

✓A statement that this practice is required by law to maintain the privacy of protected health information.

✓A statement that this practice is required to abide by the terms of the notice currently in effect.

✓Types of uses and disclosures that this practice is permitted to make for each of the following purposes: Treatment, payment and health care operations.

✓A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.

✓A description of uses and disclosures that are prohibited or materially limited my law.

✓A description of other uses and disclosures will be made only with my written authorization and that I may revoke such authorization.

✓I received notification that the members at Vista EyeCare will have access to my claims medication history through an electronic service until I revoke my consent. I understand that my consent can be revoked at any time. Revocation must be made in writing.

✓My individual rights with respect to protected health information and brief description of how I may exercise these rights in relation to:

- ○The right to complain to this practice and to the Secretary of health and human Services if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such complaint.
- ○The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction.
- ○The right to receive confidential communications of protected health information.
- ○The right to inspect and copy protected health information
- ○The right to amend protected health information
- ○The right to receive an accounting of disclosures of protected health information
- ○The right to obtain a paper copy of the notice of privacy Practices from this practice upon request. This practice reserves the right to change the terms of its Notice of Privacy Practice and to make new provisions effective for all protected health information that it maintains. I understand that can obtain this practice's current Notice of Privacy Practices on request.

Patient Name_____ Date of Birth_____
Signature_____ Date_____
Relationship to patient (if signed by a personal representative of patient):_____

Payment Policy

I hereby assign all medical benefits, including all major medical benefits to which I am entitled including Medicare, private insurance and any other health plans, to Vista EyeCare. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment. If my insurance company has not reimbursed Vista EyeCare within 60 days, **I <u>may be billed</u>** for any services or products that I have received. I understand that I am responsible for the balance due after billing. **I certify that my responses on this form are accurate to the best of my knowledge. I certify that I understand that there are no refunds or exchanges and that sales are final unless covered under manufacturer warranty or office warranty programs (office credit only).**

Signature_____ Date_____

Office use only: ▖ DFE ▖VF ▖ RP ▖Oct Screening ▖ Decline Screenings