PATIENT HISTORY FORM

Dr. Joseph Audia & Associate –2403 West Main Street Salem, WV 26426 – 345 Floral Drive. Harrisville, WV 26362

Name _____ Date _____
Occupation _____ Hobbies _____

OCULAR MEDICAL HISTORY (please explain if you respond yes)

Date of Last Eye Exam_____ Name of Last Eye Doctor_____
Do you wear glasses? [ ] YES [ ] NO _____
How often? [ ] FULL TIME [ ] DISTANCE ONLY [ ] NEAR ONLY [ ] NOT WORN
Previous Eye Injury? [ ] YES [ ] NO _____
Previous Eye Infection? [ ] YES [ ] NO _____
Previous Eye Surgery? [ ] YES [ ] NO _____
Previous Eye Allergies? [ ] YES [ ] NO _____
Are your eyes sensitive to sunlight? [ ] YES [ ] NO _____
Do you wear sunglasses while in a car? [ ] YES [ ] NO _____
Do you use a computer? [ ] YES [ ] NO If yes, how many hours of use per week? _____
Do you use prescription eye drops? [ ] YES [ ] NO _____
Do you use any OTC products on the eye? [ ] YES [ ] NO _____
Have your previous eye doctors mentioned anything out of the ordinary about your eyes?
[ ] YES [ ] NO _____

CONTACT LENS HISTORY

Have you ever worn contact lenses? [ ] YES [ ] NO _____
If Yes, what type? [ ] HARD [ ] SOFT [ ] GAS PERMEABLE
Had contact lens related complications? [ ] YES [ ] NO _____
Do you currently wear contact lenses? [ ] YES [ ] NO _____
If Yes, [ ] SOFT [ ] GAS PERMEABLE [ ] DAILY WEAR [ ] EXTENDED WEAR
[ ] DISPOSABLE [ ] NON-DISPOSABLE
Are You Interested in Wearing Contact Lenses? [ ] YES [ ] NO
If Yes, Contacts you can wear overnight? [ ] YES [ ] NO
A tint to change, enhance or illuminate your eye color [ ] YES [ ] NO
Rank in order of importance with 1 being most and 4 being least?
____ Eye Health ____ Convenience ____ Latest Technology ____ Price

GENERAL HEALTH HISTORY

Do you have allergies to any medications? [ ] YES [ ] NO If yes, please list _____
Do you currently take prescription medicine? [ ] YES [ ] NO If yes, please list _____
_____
_____
_____

CURRENT PHYSICIANS

Who is your primary care physician? _____
Are you under the care of any specialists? [ ] YES [ ] NO _____

SOCIAL HISTORY

Do you use Tobacco? [ ] YES [ ] NO
Do you use Alcohol? [ ] YES [ ] NO
Do you use Illegal Substances [ ] YES [ ] NO

SELF (Past Medical History)		FAMILY HISTORY (if yes, who?)
Cataract?	[ ] YES [ ] NO	[ ] YES [ ] NO _____
Glaucoma?	[ ] YES [ ] NO	[ ] YES [ ] NO _____
Blindness?	[ ] YES [ ] NO	[ ] YES [ ] NO _____
Diabetes?	[ ] YES [ ] NO	[ ] YES [ ] NO _____ _____
Hypertension?	[ ] YES [ ] NO	[ ] YES [ ] NO _____
Heart Disease?	[ ] YES [ ] NO	[ ] YES [ ] NO _____
Arthritis?	[ ] YES [ ] NO	
Neurologic Disease?	[ ] YES [ ] NO	
Ear/Nose/Throat Disease?	[ ] YES [ ] NO	
Gastro-Intestinal Disease?	[ ] YES [ ] NO	
Hematological Disease?	[ ] YES [ ] NO	
Skin Disease?	[ ] YES [ ] NO	
Respiratory Illness?	[ ] YES [ ] NO	

Other_____
_____

NOTICE OF PRIVACY PRACTICES – CONSENT

Dr. Joseph Audia & Associate • 2403 Main St • Salem, WV 26426 • 304-782-1005 • 782-3303 (Fax)
Dr. Joseph Audia & Associate • 345 Floral Drive • Harrisville, WV 26362 • 304-643-2117 • 643-2116 (Fax)

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Effective February 10, 2003

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our Web site.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

EYEGLASS MATERIAL There are many various materials that can be used to fabricate eyeglass lenses. We discourage the use of glass lenses, as they are the **HEAVIEST** and **LEAST SAFE** to wear. We recommend plastic. When safety is a major concern (industrial safety glasses, sports goggles, etc.), polycarbonate plastic is the **MOST IMPACT RESISTANT** material to use. Please ask us if you have any questions about your material choices.

DILATED RETINAL EVALUATION In order to provide the most thorough eye exam possible, we routinely dilate the pupil. This is done at all complete exams and at many emergency office visits. Although we realize that many of our patients drive themselves after the exam, we recommend that someone else drive you if possible.

My signature on this form will serve as a " SIGNATURE ON FILE " for processing any applicable insurance claims. I realize my insurance may deny benefits if it feels I have received examination too frequently or received exams by more than one doctor for the same illness. I agree to pay for services and / or materials, which I order but my insurance does not cover. **With the exception of Medicare and Medicaid claims, I will pay directly to this office any unpaid insurance claim that reaches 60 days past due.** I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

I ACKNOWLEDGE THAT I RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR THIS OFFICE.

_____ _____

Dated Signature of Patient or Personal Representative

_____

Print Name

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

_____ _____

Relationship to Patient Source of Authority

THANKS FOR SELECTING US TO PROVIDE YOUR CARE!

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PATIENT INFORMATION & AUTHORIZATION FOR DISCLOSURE

Effective February 10, 2003 (Revised January 31, 2013)

Patient name_____

Name (as you prefer to be called) _____ Parent's Name (if minor) _____

Patient address _____

City _____ State _____ Zip _____ E-Mail Address _____

Phone (Home) _____ Phone (Work) _____ Phone (Other) _____

Patient Social Security Number _____ Patient's Date of Birth _____

Race [ ] American Indian or Alaska Native [ ] Asian [ ] Black or African American [ ] Native Hawaiian or other Pacific Islander [ ] White

Ethnicity: [ ]Non-Hispanic or Latino [ ] Hispanic or Latino Primary Language Spoken [ ] English [ ] Spanish [ ] French [ ] Other ____

Occupation _____ Hobbies _____

How Did You Hear About Our Office? [ ] Been Patient Here Before [ ] Radio [ ]TV [ ] Newsletter [ ] Other _____
[ ] Doctor_____ [ ] A Friend_____ [ ] By Family_____ [ ] Our Staff_____ [ ] Insurance Company
[ ] Newspaper [ ] Exponent / Telegram [ ] Herald – Record [ ] Shinnston News [ ] Pennsboro News [ ] Ritchie County Gazette
[ ] Yellow Pages [ ] Frontier (Clarksburg) [ ] Armstrong Directory [ ] Mountaineer Country

Method of Payment [ ] Cash [ ] Check [ ] Visa [ ] MasterCard [ ] Discover [ ]Insurance

Medical Insurance _____ Policy Number_____ Group Number_____

Policy Holder Name_____ Social Security Number_____ Date of Birth_____

Address_____Phone Number_____

Optical Insurance _____ Policy Number_____ Group Number_____

Policy Holder Name_____ Social Security Number_____ Date of Birth_____

Address_____Phone Number_____

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which was enacted to protect the privacy of individual's Protected Health Information (PHI), our office requires your written authorization to enable us to disclose your health information to treat you, to obtain payment for our services, and to perform health care operations.
That document does not address the specific authorization for us to disclose to specific individuals of your health information to treat you, to obtain payment for our services, and to perform health care operations.
If you are age 18 years or older, and would like to authorize our office to disclose to an individual or individuals about your diagnosis, treatment or account, please provide the information requested below and sign where indicated.

[ ] I authorize the following individuals(s)

Name	Relationship
_____	_____
_____	_____
_____	_____

[ ] I reject authorization of the disclosure of information regarding my diagnosis, treatment or financial account to anyone other than those entities entitles

_____ _____
Dated Signature of Patient or Personal Representative

_____
Print Name

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

_____ _____
Relationship to Patient Source of Authority

THANKS FOR SELECTING US TO PROVIDE YOUR CARE!