Bendereye OPTOMETRY

Medical History Record

Appointment Date_____

VISION INSURANCE_____ MEDICAL INSURANCE_____

First Name (please print) _____ Last Name_____Birth Date_____M O F O

SSN:_____Street Address _____

City _____ State_____ Zip Code _____

Home Phone_____Work _____ Email _____

Employer _____ Occupation _____ Hobbies_____

Emergency Contact _____ Emergency Phone Number _____

Date of Last Eye Exam _____ Last Dilated Eye Exam _____

Personal Medical Information: Do you have problems with any of these systems?
If Yes, please check box.

- ☐ Gastrointestinal
- ☐ Nervous System
- ☐ Ear/ Nose/ Throat
- ☐ Genitourinary
- ☐ Psychological
- ☐ Blood Pressure/ Heart
- ☐ Musculoskeletal
- ☐ Blood/Lymph
- ☐ Respiratory
- ☐ Skin
- ☐ Diabetes
- ☐ Headaches
- ☐ Immunologic
- ☐ Allergy:_____

Surgeries (what type & when) _____

Are you in good health? Yes O No O

Any allergic reactions to medications or other substances? Yes O No O

If yes, please list _____

Name of general physician _____

Address of general physician _____

Please select Yes or No

Do you Smoke?Yes O No O How much?_____

Do you drink Alcohol? Yes O No O How much? _____

Do you take medications? Yes O No O Please list names & how often

_____ _

Do you use other substances? Yes O No O

Do you have family history of any of the following? If Yes, please check box.

- ☐ Diabetes
- ☐ Glaucoma
- ☐ High blood pressure
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Cataracts

Please explain any boxes you have checked _____

Do you have any of the following? If Yes, please check box.

- ☐ Red Eyes
- ☐ Eye Surgeries:_____
- ☐ Wear Glasses
- ☐ Blurred Vision
- ☐ Dry Eyes: Artificial Tears used:_____
- ☐ Eye Injuries
- ☐ Wear Contacts

Do you have any eye problems at this time? Please explain:

_____

_____

_____

Whom may we thank for referring you?_____

Payment for services is due in full at the time rendered. Bender Optometric Group is a medical and vision eye care provider. Services can be billed to your medical or vision insurance depending on the nature of your condition. Noncovered services and remaining balances will be your responsibility and billed accordingly.

Please sign below that you have reviewed all information above, it is correct to the best of your knowledge and you understand our billing policy.

_____ _____

Signature Date

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

- **To request restrictions on the health information we may use and disclose for treatment, payment and health care operations.** We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.

- **To receive confidential communications of health information about you in any manner other than described in our authorization request form**. You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.

- **To inspect or copy your health information.** You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.

- **To amend health information.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:

    - was not created by us, unless the person that created the information is no longer available to make the amendment,

    - is not part of the health information kept by or for us,

    - is not part of the information you would be permitted to inspect or copy, or

    - is accurate and complete.

- **To receive an accounting of disclosures of your health information.** You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).

- **To designate another party to receive your health information.** If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

Contact Person:

Our contact person for all questions, requests or for further information related to the privacy of your health information is:
Eric Bender, OD

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: October 1, 2013

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Bender Optometric Group, Notice of Privacy Practices.

Date _____ Patient Name_____ Signature _____