Welcome to our office

Mr. Mrs. Ms. Miss Dr. Fr.
___Single__________Married_________Other___________Date____________________

Last______________________________________First______________________________________Mi______
____

Address____Apt______________
____

City____Zip______________________Drivers
License#____________________

Home Phone___________________________
Work__________________________________Cell_______________________

Date of Birth_________/____________/____________   Age_______________ Social
Security_________________________

E-Mail____ Occupation
____

Date of last Eye Exam (estimate)________________________________ Were you Dilated _____________Y
_________N

Reason for Visit Today   (Please circle the box that applies to you)

Blurred Distance Vision	Y	N	Itch burn or Tear	Y	N	Dry Eyes	Y	N
Blurred Near Vision	Y	N	Double Vision	Y	N	Broken Glasses	Y	N
General Blurred Vision	Y	N	Amblyopia	Y	N	Flashes of Light	Y	N
Want Contact Lenses	Y	N	Cataracts evaluation	Y	N	LASIK	Y	N

____ Y ___ N Do you wear Contact Lenses if Yes Brand/Type/Powers Right
eye_______________________________________
(additional fees apply to contacts lens evaluations. Please inquire)   Left
eye_______________________________________

Health History   (Do you have problems with any of these systems?)

Good General Health	Y	N	Stomach	Y	N	Migraines	Y	N
Ear/Nose/Throat	Y	N	Urinary	Y	N	Mental	Y	N
Cardiovascular	Y	N	Bone/ Arthritis	Y	N	Metabolism	Y	N
Hypertension	Y	N	Infective Disease	Y	N	Diabetic	Y	N
Cholesterol	Y	N	Skin	Y	N	Thyroid	Y	N
Respiratory	Y	N	Neurological	Y	N	Allergic condition	Y	N
Do you smoke	Y	N	Drink alcohol	Y	N	Illegal drug use	Y	N

Ocular and Family History (Please circle the box that applies to you or circle family if it runs in the family)

Glaucoma	Y	N	family	Retinal disease	Y	N	family	Amblyopia	Y	N	family
Cataracts	Y	N	family	Other Disease	Y	N	family	Dry Eye	Y	N	family
Cataract Surgery	Y	N	family	Blindness	Y	N	family	Eye Injury	Y	N	family
Macular Degeneration	Y	N	family	Strabismus	Y	N	family	Eye Surgery	Y	N	family

List medication taken now	For what condition	List Medications taken now	For What condition
1.		5	
2.		6.	
3.		7.	
4.		8.	

Are you allergic to any medications   ____Yes ____No if so please list the medications

1)	2)	3)
4)	5)	6)

How Did you Hear about our office ___Doctor Referral ___Insurance list __From someone ___Yellow pages ___ Internet Other _______________
Are you interested in receiving information on LASIK ___Yes ___No

ADDITIONAL FEES AND INSURANCE POLICES
* There are additional fees for Contact Lens Evaluation. Please inquire
* We make no guarantees with YOUR insurance in coverage or payment. Any fee quotes with insurance are ESTIMATES only. There may be money you owe after your visit due to insurance shortages or denials.
*You authorize our office to bill your vision plan or your medical plan for a routine Eye Exam or Medical care related to your eyes. Any shortfall in payment is your Responsibility and you agree to pay us promptly when notified. If not authorized, you can pay personally and bill your insurance directly Please inquire
* I have read (on back of this form) the informed consent about dilated eye exam.
* I have read (on back of this form) and agree to the patient privacy act
* I have read (on back of this form) and agree to the retinal photo
Please sign
____

PLEASE PROVIDE THE STAFF WITH YOUR MEDICAL INSURANCE CARD AND VISION INSURANCE INFO

DIGITAL IMAGE (PHOTO) OF THE EYE- $15

Dr. Chiana has included a digital image of the eye with each eye exam before you see the Doctor. The benefit to you is a much better assessment of the health of the eyes, the retina, which will help us document, review, and compare your retina over time. Having a Photo of the eye reduces the need and how often we need to do the Dilation of the eye. It's much easier for the patient as well. Insurance will not pay for a routine image of the eye. Dr. Chiana has lowered the cost for you to **only $15 for and eyescreen (normally $85 for color fundus)** because he believes in it so much. . (State plans caloptima are excluded and need not pay)
_____Yes I agree to the $15 Fee ___ I would like to discuss this with the staff /Doctor
___ No I decline

INFORMATION REGARDING DILATING EYE DROPS –IS TODAY OK?

The Doctor may want to dilate your eyes and will talk you about it during the eye exam. If so you need to decided if today is a good day because with dilation your pupils will become unusually large and you will have blurring of vision for around 2 to 4 hours , especially for things that are close to you. Sunglasses will be provided for you because you will be sensitive to light. Driving may be difficult after an dilation for some patients , if that happens to you it's best if wait for the effects to wear off or you make arrangements not to drive yourself. Do not operate machinery. If you have difficulty with walking,balance or blurred vision, you will need to use caution when walking to prevent falls. **DILATING DROPS** are used to dilate or enlarge the pupils of the eye to allow the Eye Doctor to completely evaluate the health of your eyes. Without dilation the Doctor can not get a full view of your eye to do a complete health evaluation.. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. IF YOU HAVE PAIN IN YOUR EYES A FEW HOURS AFTER DILATION SEEK CARE AT THE ER, URGENT CARE, OR THOUGH YOUR INSURANCE AGREEMENTS. CALL OUR OFFICE FOR ADVICE. Please report to the Doctor if you have been dilated before and had some adverse side effects. Dilation needs to be done periodically, every year to every 5 years, to fully evaluate the retinal health of the eye and especially 1) All diabetics every year 2) High nearsighted patients 3) Hypertension patients 4) First time patients
_____Yes today is ok ____ I would like to Discuss with Doctor _____ No I decline
_____Not a good day. I would like to appoint for a different day for an office visit fee of $25

NOTICE OF PRIVACY PRACTICE
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE IS EFFECTIVE 12/12/02 UNTIL FURTHER NOTICE. **Right to Notice** As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPAA). Dr. Chiana's Eyecare Center can use your protected health information for treatment, payment and health care operations. a) Treatment - We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. b) Payment - We may use and disclose your health information to obtain payment for services we provide you. c) Health care operations - We may use and disclose your health information in connection

with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. **Your Authorization** Most uses and disclosures that do not fall under treatment, payment, health care operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time. **Emergency Situations** In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare. **Marketing** We will not use your health information for marketing communications without your written authorization. **Required by Law** We may also use or disclose your health information when we are required to do so by law. **Abuse or Neglect** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety. **National Security** We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances. **Appointment Reminders** We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter. **Your Rights as a Patient** You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or health care operations. -You have the right to receive confidential communications regarding your protected health information. -You have the right to inspect and copy your protected health information. -You have the right to amend your protected health information. -You have the right to receive an account of disclosures of your protected health information. -You have the right to a paper copy of this notice of privacy practices. **Legal Requirements** Dr. Chiana’s Eyecare Center is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted or are available within our office. **Complaints** If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint. **Contact Information** For further information about Dr. Steven J Chiana’s Eyecare Center’s privacy policies, please contact Dr. Steven J. Chiana Eyecare Center 1839 w Orangethorpe ave, Fullerton Ca 92833 (714) 879-2020 Dr. Steven Chiana or supervisior I understand that the above refers to my rights under the Health Insurance Portability and Accessibility Act (HIPAA). I may ask for a copy of this.

Patient Initials ______________