# WELCOME TO NUCCIO OPTOMETRISTS

Date: _____

Last: _____ First: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ____ ) _____

Work Phone: ( ____ ) _____ Ext: _____ Name: _____

SSN: _____ - _____ - _____ Date of birth: _____ / _____ / ____

Occupation: _____

Employer: _____ Distance driven: _____

Spouse/Parent: _____

Work Phone: ( ____ ) _____ Ext: _____

Number of years since last exam: 1____ 2____ 3____ 4____ 5+___

By whom: _____

Reason for your visit:

___ contact lenses
___ new glasses
___ eye redness/pain
___ annual exam
___ headache
___ broken/lost contact lens
___ broken/lost glasses
___ blur/strain looking at a distance
___ blur/strain looking near
___ blur/strain looking at computer
___other - please explain: _____

Do you presently wear contact lenses? yes_____ no _____

Number of eyeglasses you presently own: _____

Who is responsible for this account? _____

Insurance: yes _____ no_____ name: _____

Member ID: _____

## ACTIVITIES

(Please check all that apply)

___ golf
___ jogging/running
___ basketball/baseball
___ tennis/racquet sports
___ cycling
___ skiing
___ swimming/scuba diving
___ hunting/shooting
___ boating/fishing
___ hockey
___ computers
___ woodworking/metal crafts
___ automotive/driving
___ gardening/lawn care
___ music/reading
___ knitting/needlework
___ painting
___ stamp/coin collecting
___ photography
other _____

## EYE HEALTH

Do you have a history of:
___ cataracts
___ glaucoma
___ eye injury
___ eye surgery
___ lazy eye
___ eye patching
___ double vision
___ macular degeneration

Does your family have a history of:
___ cataracts
___ glaucoma
___ eye disease
___ lazy eye
___ diabetes
___ high blood pressure

## GENERAL HEALTH

Number of years since last medical exam: _____

Do you have a history of:
___ diabetes
___ high blood pressure
___ high cholesterol
___ stroke
___ heart attack
___ head injury
___ allergy
___ arthritis
___ sinus
___ tumor
___ cancer
___ HIV

If over 13:
___ alcohol use
___ tobacco use
___ illegal drug use

Any known allergy to medications?
_____

List all medications you currently take:
_____
_____
_____
_____

please continue on back if needed.

## Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Nuccio Optometrists originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privelages:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health care information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Nuccio Optometrists is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Nuccio Optometrists reserves the right to change their notice and practices and prior to implementation, in accordance with section 164.520 of the Code of Federal Regulations. Should Nuccio Optometrists change their notice, they will send a copy of any revised notice to the address I have provided (whether U.S. mail or, if I agree, e-mail).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept/decline the terms of this consent.

_____

Patient's Signature

_____

Date

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on_____.