

WELCOME TO OUR OFFICE

Dr. Alicia Reed-Thomas

PRINT NAME: FIRST _____ M. _____ LAST _____ TODAY'S DATE _____

STREET _____ BIRTH DATE _____ AGE _____

CITY _____ ST _____ ZIP _____ SOCIAL SECURITY# _____

HOME# _____ CELL# _____ SPOUSE OR PARENTS NAME _____

EMAIL _____ SSN# /ID #OF INSURED _____

ETHNICITY: HISPANIC OR LATINO: YES NO RACE: NATIVE AMERICAN ASIAN AFRICAN AMERICAN
NATIVE HAWAIIAN WHITE OTHER

TO NOTIFY YOU REGARDING APPOINTMENTS, GLASSES OR CONTACT LENSES, PLEASE CIRCLE ONE OF THE UNSECURED METHODS:

PHONE TEXT SIGNATURE _____

AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE FILING

I AUTHORIZE ALICIA REED-THOMAS, O.D. TO RELEASE TO MY INSURANCE CARRIERS, INCLUDING MEDICARE, ANY INFORMATION REQUIRED TO FILE OR RESUBMIT MY CLAIM. I FURTHER AUTHORIZE MY INSURANCE COMPANIES TO PAY ALICIA REED-THOMAS, O.D. DIRECTLY ON MY BEHALF. I FURTHER AUTHORIZE ALL INSURANCE COMPANIES INCLUDING MEDICARE SUPPLEMENTS TO PROVIDE ANY INFORMATION TO ALICIA REED-THOMAS, O.D. THAT IS REQUIRED TO RESUBMIT ANY DENIED OR INCORRECTLY PAID INSURANCE CLAIMS. THIS AUTHORIZATION REMAINS IN EFFECT UNTIL WITHDRAWN BY ME.

SIGNATURE _____

AUTHORIZATION TO DISCUSS YOUR INFORMATION WITH FAMILY OR CAREGIVERS

TO COMPLY WITH THE NEW HIPPA FEDERAL PRIVACY REGULATIONS, WE MUST RECEIVE YOUR WRITTEN APPROVAL TO DISCUSS YOUR CASE WITH ANYONE ELSE INCLUDING YOUR SPOUSE, CHILDREN, FAMILY MEMBERS, CAREGIVERS, FRIENDS, ETC. BY AUTHORIZING THIS, WE WILL BE ABLE TO, WITHOUT REQUIRING YOUR PRESENCE, DISCUSS YOUR CASE, ANSWER QUESTIONS, LEAVE DETAILED MESSAGES, AND CONTACT, IN THE EVENT OF AN EMERGENCY, THE PERSON(S) LISTED BELOW. IF YOU WOULD LIKE US TO ANSWER QUESTIONS OR DISCUSS YOUR CASE TO ANYONE OTHER THAN YOURSELF, YOU MUST INCLUDE THEM BELOW. THIS AUTHORIZATION IS OPTIONAL AND CAN BE WITHDRAWN AT ANY TIME.

NAME _____ NAME _____ NAME _____

RELATIONSHIP _____ RELATIONSHIP _____ RELATIONSHIP _____

PHONE# _____ PHONE# _____ PHONE# _____

SIGNATURE _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone#() - _____

HIPAA COMPLIANCE ACKNOWLEDGEMENT OF RECEIPT

I ACKNOWLEDGE THAT I WAS OFFERED A COPY OF ALICIA REED-THOMAS, O.D.'S NOTICE OF PRIVACY PRACTICES EFFECTIVE MARCH 1, 2015

PATIENT NAME _____

SIGNATURE _____ DATE _____

HEALTH HISTORY

FAMILY DR. _____ DATE OF LAST EYE EXAM _____ BY _____

EXPLAIN ANY VISION PROBLEMS _____

DO YOU WEAR GLASSES? Y N DO YOU WEAR CONTACTS? Y N TYPE/BRAND of CONTACTS: _____

DO YOU USE A COMPUTER OR OTHER ELECTRONIC DEVICE? Y N HOURS A DAY _____

OCULAR HISTORY: CATARACTS GLAUCOMA MACULAR DEGENERATION LAZY EYE RETINAL CONDITION
EYE INJURY IF YES TO ANY PLEASE GIVE DETAILS _____

YOUR MEDICAL HISTORY- CIRCLE ALL THAT APPLY

CARDIOVASCULAR: HIGH BLOOD PRESSURE CHOLESTEROL HEART DISEASE ARRHYTHMIA STROKE
CONGESTIVE HEART FAILURE OTHER _____

EAR/NOSE/THROAT/MOUTH: ALLERGIES SINUSITIS HEARING LOSS VERTIGO OTHER _____

RESPIRATORY: ASTHMA EMPHYSEMA COPD CHRONIC BRONCHITIS SLEEP APNEA OTHER _____

GASTROINTESTINAL: HEPATITIS ULCERS REFLUX CROHN'S INDIGESTION OTHER _____

GENITOURINARY: (KIDNEY – FAILURE INFECTION STONES TRANSPLANT DIALYSIS) MENOPAUSE SYMPTOMS STD
INCONTINENCE OVARIAN CYSTS RECURRENT URINARY TRACT INFECTIONS OTHER _____

MUSCULOSKELETAL: ARTHRITIS RHEUMATOID ARTHRITIS MUSCULAR DYSTROPHY FIBROMYALGIA GOUT
MULTIPLE SCLEROSIS CEREBRAL PALSY OTHER _____

INTEGUMENTARY: BASIL CELL CARCINOMA DERMATITIS ECZEMA PSORIASIS SHINGLES OTHER _____

NEUROLOGICAL: MIGRAINES BELL'S PALSYP DIZZINESS EPILEPSY PARALYSIS PARKINSON'S SEIZURES STROKE TIA
HEAD INJURY TUMOR ALZHEIMER'S CONFUSION OTHER _____

PSYCHIATRIC: DEPRESSION BIPOLAR ADD/ADHD CONFUSED PTSD DEMENTIA PANIC EPISODES VIOLENT PARANOIA
ANXIETY OTHER _____

ENDOCRINE: TYPE 1 DIABETIC TYPE 2 DIABETIC HYPOGLYCEMIC THYROID OTHER _____

HEMATOLOGIC/LYMPHATIC: ANEMIA BLOOD DISORDER LEUKEMIA LYMPHOMA OTHER _____

ALLERGIC/IMMUNOLOGIC: HIV LUPUS IMMUNE DISORDER SEASONAL ALLERGIES OTHER _____

DEVELOPMENTAL: PREMATURE DELIVERY COMPLICATED DELIVERY BIRTH DEFECT OTHER _____

CONSTITUTIONAL/METABOLIC: NIGHT SWEATS FATIGUE EXCESSIVE THIRST HUNGER HOT FLASHES

CANCER: Type _____ ACTIVE OR IN REMISSION **WOMAN ONLY:** POSSIBLY PREGNANT NOW? Y N

TOBACCO HISTORY:	Never Smoker	ALCOHOL:	Current non-drinker of alcohol
	Former Smoker		Social Drinker
	Current some day smoker		Daily Drinker
	Current every day smoker		

FAMILY HEALTH HISTORY

FAMILY MEMBER			FAMILY MEMBER		
GLAUCOMA	Y N	_____	HIGH CHOLESTEROL	Y N	_____
CATARACTS	Y N	_____	KIDNEY DISEASE	Y N	_____
MACULAR DEGEN	Y N	_____	CANCER	Y N	_____
RETINAL DISEASE	Y N	_____	HEART DISEASE	Y N	_____
LAZY EYE	Y N	_____	HIGH BLOOD PRESSURE	Y N	_____
BLINDNESS	Y N	_____	STROKE	Y N	_____
DIABETES	Y N	_____	THYROID PROBLEM	Y N	_____

KNOWN DRUG ALLERGIES _____

SURGERIES _____

CURRENT MEDICATIONS (RX AND OVER THE COUNTER)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

