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

I GIVE PERMISSION TO NOTIFY ME VIA UNSECURED METHOD OF PHONE OR TEXT, AND LEAVE VOICEMAIL/MESSAGE REGARDING APPOINTMENTS, GLASSES OR CONTACT LENSES. 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 THIS AUTHORIZATION REMAINS IN EFFECT UNTIL WITHDRAWN BY ME.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 THIS AUTHORIZATION IS OPTIONAL AND CAN BE WITHDRAWN AT ANY TIME.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/E-RX CONSENT

I ACKNOWLEDGE THAT I WAS OFFERED A COPY OF ALICIA REED-THOMAS, O.D.'S NOTICE OF PRIVACY PRACTICES EFFECTIVE MARCH 1, 2015. I GIVE CONSENT TO ACCESS THE E-RX DATABASE AND DOWNLOAD NECESSARY RX HISTORY.

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 MUTIPLE SCLEROSIS CEREBRAL PALSY OTHER _____

INTEGUMENTARY: BASIL CELL CARCINOMA DERMATITIS ECZEMA PSORIASIS SHINGLES OTHER _____

NEUROLOGICAL: MIGRAINES BELL'S PALSY 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

Former Smoker

Current some day smoker

Current every day smoker

ALCOHOL:

Current non-drinker of alcohol

Social Drinker

Daily Drinker

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)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____