

Patient Information

Name: Mr. Ms. Mrs. Dr. _____
(First) (Middle) (Last)

SSN: _____ - _____ - _____ Date of Birth: _____ / _____ / _____ Sex: Male Female

Street Address (or PO Box): _____

City: _____ State: _____ Zip: _____

Single Married Separated Divorced Widowed Life Partner

Phone: (H) _____ - _____ - _____ (W) _____ - _____ - _____ (Cell) _____ - _____ - _____

May we leave a message on your home, work, or cell phone regarding appointment reminders? Yes No

Email Address: _____

Emergency Contact: _____ Emergency Contact Phone: _____

How did you learn about our practice? Dr. Referral Family/Friend Yellow Pages RutzenEye.com
 Insurance Directory Other _____

Responsible Party Information

Party responsible for patient's bill: **SELF** Spouse Parent Other

Name: Mr. Ms. Mrs. Dr. _____
(First) (Middle) (Last)

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Phone: (H) _____ - _____ - _____ (W) _____ - _____ - _____ (Cell) _____ - _____ - _____

Your Doctors

Primary Care Physician: _____ Phone: _____ - _____ - _____

Referring Physician: _____ Phone: _____ - _____ - _____

Other Physician: _____ Phone: _____ - _____ - _____

I certify that the information above is accurate and true to the best of my knowledge and is only to be used for treatment, billing, & processing of insurance benefits. I will not hold my physician or any member of Rutzen Eye Specialists (RES) responsible for any errors or omissions that I have made in the completion of this form. I further authorize the release of any necessary information, including medical information, to my insurance company in order to determine insurance benefits to which I may be entitled. This authorization may be revoked by me at any time in writing. I authorize RES to release and or send medical information regarding my case to other consulting and/or referring physicians. I understand and agree that regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered. I understand that without a proper referral or authorization from my HMO/PPO, I am financially responsible for charges incurred for services rendered by RES on all dates of service. I also understand that I alone am responsible for obtaining my authorization or referral from my HMO/PPO primary care physician. I understand that I am responsible for charges incurred for services considered to be non-covered by my HMO/PPO.

Signature: _____ Date: _____ / _____ / _____

Medical Questionnaire

If you are a woman, is there a chance you might be pregnant? Yes No

What is your profession?

Do you have any activities with special vision requirements? (pilot, firearms, art, etc.)

Do you wear glasses? Yes No

Do you wear contact lenses? Yes No

Have you had any previous eye problems or eye surgeries?

Do you take any eye drops? Yes No

Medication	Which eye? (R, L, both)	How many times/day?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take any other medications? Yes No
(Please list names only.)

_____	_____
_____	_____
_____	_____

Do you have allergies to medication? Yes No

Medication experienced	Reaction or problem
_____	_____
_____	_____
_____	_____
_____	_____

Past Medical History

Do you have any of the following conditions? (Check those that apply.) NONE

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heartburn/reflux | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Poor breathing | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Irritable bowel disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Irregular heart | <input type="checkbox"/> Depression | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Enlarged prostate | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraines | |

Other _____

Past Medical History *(continued)*

Does anyone in your family have any of the following: **NONE**

- Macular degeneration Relation: _____
- Glaucoma Relation: _____
- Other eye disease Relation: _____

Do you smoke? Yes No Formerly

If yes, how many packs per day? _____
how many years? _____

Do you drink alcohol? Yes No

If yes, how much? _____

Have you recently experienced any of these symptoms? *(Check those that apply.)* **NONE**

General

- fatigue
- fevers
- weight gain/loss

Ear/Nose/Throat

- hearing loss
- cold or flu-like symptoms
- sinus problems

Breathing

- cough
- wheezing
- shortness of breath

Heart

- chest pain or pressure
- palpitations (feeling of an irregular heart beat)
- leg swelling

Gastrointestinal

- abdominal pain
- nausea
- vomiting
- constipation

Genital/Urinary

- pain with urination
- blood in the urine
- genital sores

Skin

- rashes

Hormonal

- excessive thirst
- feeling cold or hot
- bulging eyes

Neurological

- headaches
- dizziness
- numbness of extremities

Psychological

- emotional problems
- psychological problems

Musculoskeletal

- arthritis
- joint swelling
- weakness

Blood

- easy bruising/bleeding

Summary Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This is a brief summary of your privacy rights and the privacy practices of Rutzen Eye Specialists and its affiliated facilities. Please also read our FULL Notice of Privacy Practices for a full description of our practices and of your rights. Please review this notice carefully.

Rutzen Eye Specialists, along with your Primary Care Physician, Referring Physician, & all other Physicians / facilities who participate in your care are allowed to share medical information with each other as part of an organized health care arrangement for treatment, payment, and operational activities. We will use this information in order to provide our patients complete & comprehensive health care services. If you have any questions with either our Summary or Full Notice of Privacy Practices, please contact Tanya Kelly, Rutzen Eye Specialists Office Manager at (410) 975-0090.

Our Commitment

We are committed to protecting your Private Health Information. As health care providers, Rutzen Eye Specialists is required by law to keep health information about you private, to give you our Notice about our privacy practices and to follow the practices outlined in our Full Privacy Notice.

How We May Use and Disclose Your Information

We may use your Private Health Information treatment, payment, and health care operations. Under certain circumstances, Rutzen Eye Specialists may also disclose your Private Health Information for other purposes without your written permission. We may give out information about you for public health purposes; to report abuse, neglect, or domestic violence, for health oversight audits or inspections, for certain approved research purposes, for funeral arrangements or organ donations, to government programs, to workers' compensation, and in emergency situations. We may also disclose health information when required by law, such as in response to a request from law enforcement or in response to a court order. We may also contact you for appointment reminders and to tell you about possible treatment options and health services. In addition, we may also disclose health information about you to family, relatives, friends, or caregivers who may be involved in your care for treatment and payment purposes.

Your Rights Concerning Your Health Information

You may ask to review or receive copies of your health information. There may be a fee for this service. You may ask us to amend health information in your medical or billing records you believe is incorrect or incomplete. You may request an accounting of certain disclosures we have made from your records. You may request alternate forms of communications. You may ask us to restrict how we use or disclose your Private Health Information. You may complain to us and to the federal government if you believe your privacy rights have been violated. You have a right to a paper copy of our current Full Privacy Notice. We will consider your request, but we may not agree if we are not required by law to do so.

We reserve the right to make changes to this summary Notice and will post a copy of the current Full Privacy Notice in locations where treatment is provided.

Signature: _____ Date: _____