

PATIENT INFORMATION

Patients Legal Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Name of Spouse or Legal Guardian: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Information:

Home: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Work: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Cell/Mobile: (\_\_\_\_) \_\_\_\_-\_\_\_\_

EMAIL Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address:

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

INSURANCE INFORMATION:

Name of Medical Insurance: \_\_\_\_\_

Member ID: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_

Customer Svc. Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Name of Vision Insurance: \_\_\_\_\_

Member ID: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_

Customer Svc. Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Referral Information – How did you learn about our office? Please check all that apply.

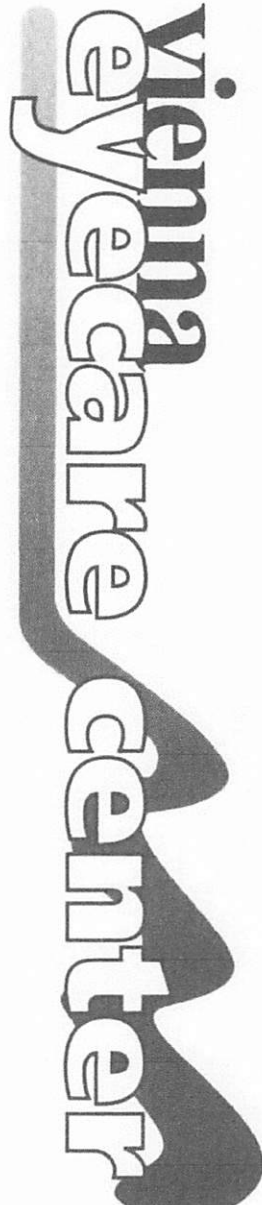
- Relative
- Friend
- Internet
- Doctor Referral
- Insurance
- Location
- Other

If you were referred by a current patient, whom may we thank? \_\_\_\_\_

I hereby authorize any necessary treatment by the optometrists in the practice of Dr. Snively and agree to be responsible for my bill and any collection fees made necessary to collect payment of services rendered. I authorize this office to release any information necessary to expedite insurance claims. I further authorize the office of Dr. Snively to release or obtain information from my attending physician or any medical facility.

Patient's Signature/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Interest charge 1.5% per month or 18% per annum. Attorney's fees added if necessary for collection.



# Medical History Questionnaire

Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Guardian (If Applicable): \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_ Last Eye Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Name of Medical Doctor: \_\_\_\_\_ Dr.'s Phone \_\_\_\_\_  
 Last Medical Exam: \_\_\_\_\_

**Medical History**

Do you have any allergies to medications?  No  Yes If yes, explain: \_\_\_\_\_

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

\_\_\_\_\_

vienna  
eyecare center

List all major injuries, surgeries and/ or hospitalizations you have had: C. Richard Snively, Jr., O.D.

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: \_\_\_\_\_

Are you pregnant and/ or nursing?  No  Yes  
 Do you wear glasses?  No  Yes If yes, how old is your present pair of lenses? \_\_\_\_\_  
 Do you wear contact lenses?  No  Yes If yes, how old is your present pair of lenses? \_\_\_\_\_  
 Type of contact lenses:  Rigid  Soft  Extended Wear  Other Are they comfortable?  No  Yes  
 If Disposable, how often do you change lenses? \_\_\_\_\_

**Family History**

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**\*Please turn this form over and complete side two\***

# Social History

*This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

Do you drive?  No  Yes If yes, do you have visual difficulty when driving?  No  Yes If yes, please describe:

Do you use tobacco products?  No  Yes If yes, type/amount/how long: \_\_\_\_\_  
 Do you drink alcohol?  No  Yes If yes, type/amount/how long: \_\_\_\_\_  
 Do you use illegal drugs?  No  Yes If yes, type/amount/how long: \_\_\_\_\_  
 Have ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis

## Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	N	Y	?		N	Y	?
<b>CONSTITUTIONAL</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>EARS, NOSE, MOUTH, THROAT</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever, Weight Loss/ Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>INTEGUMENTARY (Skin)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>NEUROLOGICAL</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>EYES</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>RESPIRATORY</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>VASCULAR/CARDIOVASCULAR</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>GASTROINTESTINAL</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>GENITOURINARY</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BONES / JOINTS / MUSCLES</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>LYMPHATIC / HEMATOLOGIC</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tires Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ENDOCRINE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/ Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>ALLERGIC / IMMUNOLOGIC</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<b>PSYCHIATRIC</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

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Doctors Signature \_\_\_\_\_ Date \_\_\_\_\_ Year (1) Year (2) Year (3)

## **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

The law gives you many rights regarding your personal health information.

You may ask us to restrict our uses and disclosures for purposes of treatment (except in emergency care), payment, or business operations. This request must be made in writing to Privacy Officer named at the beginning of this Notice. We do not have to agree to your request, but if we agree, must honor the restrictions you ask for.

You may ask us to communicate with you in a confidential manner. Examples might be only contacting you by telephone at your home or using some special email address. We will accommodate these requests if they are reasonable and if you agree to pay any additional cost, if any, incurred in accommodating your request. Requests for special communication requests must be made to the Privacy Officer named at the beginning of this Notice.

You may ask to review or get copies of your health information. There are a very few limited situations in which we may refuse your access to your health information. For the most part we are happy to provide you with the opportunity to either review or obtain a copy of your medical information. All requests for review or copy of medical information must be made in writing to the Privacy Officer named at the beginning of this Notice. While we usually respond to these requests in just a day or so, by law we have fifteen (15) days to respond to your request. We may request an additional thirty (30) day extension in certain situations.

Health care information you request copies of may be delivered to you in electronic format. The e-formats Vienna Eyecare Center/ C. Richard Snively Jr., OD has approved as secure and protects the integrity of your health care information include secure email, an authorized Electronic Health Information system and media supplied by Vienna Eyecare Center/ C. Richard Snively Jr., OD.

You may ask us to amend or change your health care information if you think it is incorrect or incomplete. If we agree, we will make the amendment to your medical record within thirty (30) days of your written request for change sent to the Privacy Officer named at the beginning of this Notice. We will then send the corrected information to you or any other individual you feel needs a copy of the corrected information. If we do not agree, you will be notified in writing of our decision. You may then write a statement of your position and we will include it in your medical record along with any rebuttal statement we may wish to include.

You may request a list of any non-routine disclosures of your health information that we might have made within the past six (6) years (or a shorter period if you wish). Routine disclosures would include those used your treatment, payment, and business operations of Vienna Eyecare Center/ C. Richard Snively Jr., OD. These routine disclosures will not be included in your list of disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you must pay for them in advance at a fee of \$0.00per list. We will usually respond to your written request (made to the Privacy Officer named at the beginning of this Notice) within thirty (30) days but we are allowed one thirty (30) day extension if we need the time to complete your request.

You may obtain additional copies of this Notice of Privacy Practices from our business office or online at our website address shown at the beginning of this Notice.

## **CHANGING OUR NOTICE OF PRIVACY PRACTICES**

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to substantially change the Notice. We reserve the right to change this Notice at any time. If we change this Notice, the new privacy practices will apply to your existing health information as well as any additional information generated in the future. If we change this Notice, we will post a new Notice in our office and on our website.

## **COMPLAINTS**

If you think that anyone at Vienna Eyecare Center/ C. Richard Snively Jr., OD has not respected the privacy of your health information, you are free to complain to the Privacy Officer named at the beginning of this Notice. We are more than happy to try to resolve any concern you may have in writing. If we cannot resolve your concern at that level, you may also file a complaint with the U.S. Department of Health and Human Services Office of Civil Rights or the Virginia Attorney