REGISTRATION FORM

TODAY'S DATE ___________________________

FULL NAME ___________________________ DATE OF BIRTH___________________________

NICK NAME OR PREFERRED NAME ___________________________ SSN __________-_______-____________________

ADDRESS ___________________________ HOME PHONE ___________________________

___________________________ CELL PHONE ___________________________

EMAIL ADDRESS ___________________________ WORK PHONE ___________________________

OCCUPATION ___________________________ EMERGENCY CONTACT ___________________________

EMPLOYER / SCHOOL ___________________________ EMERGENCY CONTACT PH#___________________________

VISION INSURANCE INFORMATION:

VSP MES EYEMED OTHER ___________________

INSURANCE SUBSCRIBER INFORMATION: **CHECK BOX IF PATIENT IS THE INSURANCE SUBSCRIBER**

SUBSCRIBER NAME ___________________________

SUBSCRIBER SSN __________-_______-____________________

SUBSCRIBER DATE OF BIRTH___________________________

MEDICAL INSURANCE INFORMATION:

PRIMARY MEDICAL INSURANCE PLAN ___________________________ (PLEASE PRESENT CARD)

SECONDARY MEDICAL INSURANCE PLAN ___________________________ (PLEASE PRESENT CARD)

RESPONSIBLE PARTY INFORMATION:

CHECK BOX IF PATIENT IS RESPONSIBLE FOR ACCOUNT

FULL NAME ___________________________ DATE OF BIRTH___________________________

ADDRESS ___________________________ HOME PHONE ___________________________

___________________________ CELL PHONE ___________________________

RELATIONSHIP TO PATIENT ___________________________ SSN __________-_______-____________________

PLEASE READ AND SIGN:

CONTACT LENS WEARERS: Contact lens wearers require additional time, testing, consultation, and expertise. Therefore a **separate** contact lens evaluation or fitting fee will be applied for both new and existing contact lens wearers.

PAYMENT POLICY: Professional fees are due and payable at the time services are rendered.

PATIENTS USING VISION OR MEDICAL INSURANCE: I request that payment of authorized vision or medical insurance benefits be made directly to Pacific Eye Care Doctors of Optometry for any goods or services furnished. I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that I am financially responsible for all charges, whether or not paid by the insurance, for all services rendered on my behalf.

____ ___________________________

Signature of Patient (parent/guardian if minor) Date

MEDICAL HISTORY FORM

FULL NAME ______________________________ TODAY'S DATE ______________________

OCULAR HISTORY:

DATE OF BIRTH______________________

Have you **recently** been experiencing any of the following problems with your eyes? **Check the box if "Yes."**

Blurred Vision	Flashes / Floaters in Vision	Redness
Loss of Vision	Halos / Glare / Light Sensitivity	Excess Tearing / Watering
Loss of Side Vision	Dryness	Eye Pain or Soreness
Distorted Vision	Sandy or Gritty Feeling	Mucous Discharge
Double Vision	Burning	Inflammation of the Eyelid
Tired Eyes	Itching	Styes or Chalazion

Have you **ever** been diagnosed with or had problems with any of the following ocular conditions? **Check the box if "Yes."**

Cataracts	Glaucoma	Retinal Detachment / Disease
Crossed Eyes	Lazy Eye / Amblyopia	Dry Eye
Eye Injury	Macular Degeneration	Other ______________

Approximate date of last eye exam: ______________ Doctor/Location: ________________________

MEDICAL HISTORY:

List any medications you are currently taking (include oral contraceptives, aspirin, over the counter medications):

____

____

____

Are you allergic to any medications? No Yes If yes, which ones: ________________________

____

List all major surgeries and / or hospitalizations you have had: ________________________

____

SOCIAL HISTORY:

Do you use tobacco products? No Yes If yes, type / amount / how long:______________________

Do you use drink alcohol? No Yes If yes, type / amount / how long:______________________

Do you use illegal drugs? No Yes If yes, type / amount / how long:______________________

FAMILY HISTORY:

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

	RELATION TO YOU		RELATION TO YOU
Glaucoma	______________	Diabetes	______________
Cataract	______________	Cancer	______________
Macular Degeneration	______________	Heart Disease	______________
Retinal Detachment	______________	High Blood Pressure	______________
Blindness	______________	Kidney Disease	______________
Crossed Eyes	______________	Lupus / Arthritis	______________

REVIEW OF SYSTEMS:

Please check the box beside any problem you currently have, or have had, in the following areas:

ALLERGIC / IMMUNOLOGIC All Normal
- Allergy / Hay Fever

CARDIOVASCULAR / CARDIAC All Normal
- Arteriosclerosis
- Heart Disease
- High Blood Pressure
- High Cholesterol

CONSTITUTIONAL All Normal
- Fever
- Weight Loss / Gain

EARS, NOSE, MOUTH, THROAT All Normal
- Sinus Congestion
- Dry Throat / Mouth

ENDOCRINE All Normal
- Diabetes
- Thyroid Disease

GASTROINTESTINAL All Normal
- Diarrhea / Constipation
- IBS / Crohn’s Disease

GENITOURINARY All Normal
- Genitals
- Kidney / Bladder

HEMATOLOGIC / LYMPHATIC All Normal
- Anemia
- Bleeding Problems
- Breast Cancer

INTEGUMENTARY (Skin) All Normal
- Cancer
- Rashes
- Easy Bruising

MUSCULOSKELETAL All Normal
- Rheumatoid Arthritis
- Muscle Pain
- Joint Pain

NEUROLOGICAL All Normal
- Migraines
- Dizziness
- Seizures

PSYCHIATRIC All Normal
- Anxiety
- Depression

RESPIRATORY All Normal
- Asthma
- Bronchitis / Emphysema

If you checked any of the above boxes or have a condition not listed, please explain further: ____________________

____

____

____

____ ________________________

Signature of Patient (parent/guardian if minor) Date

____ ________________________

Physician’s signature Date

Acknowledgment of Receipt of Notice of Privacy Practices

PACIFIC EYE CARE DOCTORS OF OPTOMETRY
16450 Bolsa Chica St, Huntington Beach, CA 92649

Effective Date: January 1, 2013

I hereby acknowledge that I received a copy of the Notice of Privacy Practices for the above medical practice. I further acknowledge that a copy of the current notice is posted in the reception area and any amended Notice of Privacy Practices will be made available at my next appointment.

Signed: ___________________________________ Date: _________________________

Print Name: ________________________________ Telephone: _____________________

If not signed by the patient, please indicate:

Relationship:

parent or guardian of minor patient
guardian or conservator of an incompetent patient
beneficiary or personal representative of deceased patient

Name of Patient: ____

--- office use only ---

Notice of Privacy Practices Acknowledgment Tracking Information

Complete the following only if the Patient refuses to sign the Acknowledgment:

Efforts to Obtain: ____

Reasons for Refusal: ____

____

Employee Name: ____

Notice of Privacy Practices

Effective date of notice: **January 1, 2013**

PACIFIC EYE CARE DOCTORS OF OPTOMETRY
WALTER YIM, OD, APC
16450 Bolsa Chica St
Huntington Beach, CA 92649
Office Phone (714) 840-1366
Office FAX (714) 846-9415 E-Mail info@pacificeyecare.net

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

General Rule

We respect our legal obligation to keep health information, that identifies you, private. The law obligates us to give you notice of our privacy practices.

Generally, we can only use your health information in our office or disclose it outside of our office, without your written permission, for purposes of treatment, payment or healthcare operations. In most other situations, we will not use or disclose your health information unless you sign a written authorization form. In some limited situations, the law allows or requires us to disclose your health information without written authorization.

Uses or Disclosures of Health Information

Examples of how we use information for **treatment** purposes:

- When we set up an appointment for you.
- When our technician or doctor tests your eyes.
- When the doctor prescribes glasses or contact lenses.
- When the doctor prescribes medication.
- When our staff helps you select and order glasses or contact lenses.
- When we show you low vision aids.

We may disclose your health information outside of our office for **treatment** purposes, for example:

- If we refer you to another doctor or clinic for eye care or low vision aids or services.
- If we send a prescription for glasses or contacts to another professional to be filled.
- When we provide a prescription for medication to a pharmacist.
- When we phone to let you know that your glasses or contact lenses are ready to be picked up.

Sometimes we may ask for copies of your health information from another professional that you may have seen before.

We may use your health information within our office or disclose your health information outside of our office for **payment** purposes. Some examples are:

- When our staff asks you about health or vision care plans that you may belong to, or about other sources of payment for our services.
- When we prepare bills to send to you or your health or vision care plan.
- When we process payment by credit card and when we try to collect unpaid amounts due.
- When bills or claims for payment are mailed, faxed, or sent by computer to you or your health or vision plan.
- When we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.

We use and disclose your health information for **healthcare operations** in a number of ways. Health care operations mean those administrative and managerial functions that we have to do in order to run our office. We may use or disclose your health information, for example, for financial or billing audits, for internal quality assurance, for personnel decisions, to enable our doctors to participate in managed care plans, for the defense of legal matters, to develop business plans, and for outside storage of our records.

Appointment Reminders

We may call to remind you of scheduled appointments. We may also notify you of other treatments or services available at our office that might help you.

Uses & Disclosures without an Authorization

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never happen at our office at all. Such uses or disclosures are:

- A state or federal law that mandates certain health information be reported for a specific purpose.
- Public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the Food and Drug Administration regarding drugs or medical devices.
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence.
- Uses and disclosures for health oversight activities, such as for the licensing of doctors, audits by Medicare or Medicaid, or investigation of possible violations of healthcare laws.

- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies.
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else.
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations.
- Uses or disclosures for health related research.
- Uses and disclosures to prevent a serious threat to health or safety.
- Uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the Foreign Service.
- Disclosures relating to workers' compensation programs.
- Disclosures to business associates who perform healthcare operations for us and who agree to keep your health information private.

Other Disclosures

We will not make any other uses or disclosures of your health information unless you sign a written **authorization form**. You do not have to sign such a form. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it.

Your Rights Regarding Your Health Information

The law gives you many rights regarding your health information.

- You can ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or healthcare operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to **Walter Yim, OD** at the address, fax or e-mail shown at the beginning of this notice.
- You can ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using e-mail to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to **Walter Yim, OD** at the address, fax or e-mail shown at the beginning of this notice.
- You can ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. Primarily, however, you will be able to review or have a copy of your health information within 30 days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally required. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we sent you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to **Walter Yim, OD** at the address, fax or e-mail shown at the beginning of this notice.
- You can ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to **Walter Yim, OD** at the address, fax or e-mail shown at the beginning of this notice.
- You can get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want), except disclosures for purposes of treatment, payment or health care operations, disclosures made in accordance with an authorization signed by you, and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to **Walter Yim, OD** at the address, fax or e-mail shown at the beginning of this notice.

Our Notice of Privacy Practices

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time in compliance with and as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have, as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office and have copies available in our office.

Complaints

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to **Walter Yim, OD** at the address, fax or e-mail shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone.

For More Information

If you want more information about our privacy practices, call or visit **Walter Yim, OD** at the address or phone number shown at the beginning of this notice.