(Please Print) Confidential Case History Date_____

Name: (L) _____(F)_____(MI)_____Age:_____Sex:_____

Address:_____City_____Zip_____Birth Date_____

Home Phone:_____Work Phone:_____Occupation:_____

Have you been examined here before? Yes/No If yes, when?_____

Date of Last Eye Exam:_____Previous Eye Doctor:_____

Medical Insurance:_____Vision Insurance:_____

Do YOU have any of the following?

High Blood Pressure	Y....N	Glaucoma	Y....N
Diabetes	Y....N	Cataracts	Y....N
Cancer	Y....N	Double Vision	Y....N
Thyroid Problems	Y....N	Frequent Headaches	Y....N
Arthritis	Y....N	Seeing Spots or Flashes	Y....N
Eye Turn or "Lazy Eye"	Y....N	Any Eye Disease	Y....N

Other Medical Conditions:_____

Females.. Are you pregnant? Yes/No If yes, how many weeks?_____

Do any of your blood relatives have any of the following? Please specify relationship on line...

Diabetes	Y....N	Cataracts	Y....N
Glaucoma	Y....N	Any Eye Disease	Y....N

Please list any current medications you are taking (including birth control and over the counter):

_____

_____

Please list any allergies that you have (including medications):_____

_____

Have you ever had surgery on your eyes, or an eye injury? Yes/No If yes, describe:_____

_____

Have you ever worn glasses.....Y....N Prescribed or over the counter_____
Have you ever worn contact lenses....Y....N Are you currently wearing contacts....Y....N
Do you sleep in your contacts.....Y....N Daily wear or disposable Clear or color
Do you intend to wear contacts during the next year.....Y....N

What is the main reason for your visit today?_____

_____

By signing below, I consent Optometric treatment.

Signature:_____Date:_____

BROWN'S EYE CENTER
PATIENT ACKNOWLEDGMENT FORM

Patient Acknowledgment of Understanding of Privacy Practices

Patient's name_____

I understand that the patient's health information is private and confidential. I understand that Brown's Eye Center works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Brown's Eye Center may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Brown's Eye Center has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgment. I understand that I have the right to read the "Notice" before signing this Acknowledgement.

Brown's Eye Center may update this Acknowledgment and "Notice of Privacy Practices". If I ask, Brown's Eye Center will provide me with the most current "Notice of Privacy Practices".

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

Brown's Eye Center has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Brown's Eye Center by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of Brown's Eye Center's "Notice of Privacy Practices".

Patient's Signature _____ Date_____