WELCOME TO JOHNSON EYECARE
4622 PROGRESS DR. SUITE B DAVENPORT, IA 52807

PATIENT INFORMATION

PATIENT NAME: _____ SEX M F

ADDRESS:_____ CITY _____ STATE_____ ZIP_____

CELL PHONE_____ HOME PHONE_____

EMAIL ADDRESS_____ WORK PHONE _____

DATE OF BIRTH _____/_____/_____ PATIENT SS # _____

EMPLOYER/SCHOOL_____ OCCUPATION/GRADE_____

EMERGENCY CONTACT:_____

EMERGENCY CONTACT DOB: _____/_____/_____ EMERGENCY NUMBER_____

REASON FOR TODAY'S VISIT:_____

LAST EXAM_____ BY WHOM_____

DO YOU WEAR: GLASSES CONTACTS BOTH NONE

IF YOU WEAR CONTACT LENSES:

WHAT TYPE/BRAND?_____ CLEANING SYSTEM _____

ARE YOU INTERESTED IN CONTACTS? YES / NO

IF YES, ARE YOU INTERESTED IN: DISPOSABLES? SLEEPING WITH? COLOR? OTHER?

DO YOU HAVE SUNGLASSES OR CLIP-ONS? YES / NO

ARE YOU INTERESTED IN CORRECTIVE SURGERY? YES / NO

DO YOU HAVE TROUBLE WITH GLARE OR REFLECTIONS? YES / NO

DO YOU WORK ON A COMPUTER? YES / NO

HOBBIES/SPORTS? _____

I, the undersigned, assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes not paid by insurance. Payment for services, glasses, and contacts are due, in full, unless other arrangements have been agreed upon. I hereby authorize the use of this signature on all insurance submissions.

X_____ _____

RESPONSIBLE PARTY SIGNATURE DATE

HEALTH HISTORY

Please complete the following to the best of your knowledge. It is necessary for us to have complete knowledge of all medications and physical ailments to provide the best care for your eyes and vision. Many medications have ocular/visual side effects, though usually rare, and some systemic diseases/disorders may also contribute or be related to the eyes. Thank you for your cooperation.

PLEASE CHECK ALL THAT APPLY

1. HAVE YOU OR ANY BLOOD RELATIVES BEEN DIAGNOSED AND/OR TREATED FOR THE FOLLOWING?

CONDITION	SELF YES	SELF NO	FAMILY YES	HOW LONG/WHICH RELATIVE?
DIABETES				
HIGH BLOOD PRESSURE				
THYROID CONDITIONS				
HEART CONDITIONS				
GLAUCOMA				
MACULAR DEGENERATION				
EYE TURN AND/OR LAZY EYE				
BLINDNESS				
CATARACTS				

2. HAVE YOU BEEN DIAGNOSED WITH AND/OR TREATED FOR ANY OF THE FOLLOWING?

(PRESENT OR PAST)

CONDITIONS	YES	NO	HOW LONG? WHEN?
HIGH CHOLESTEROL			
STROKE			
NEUROLOGICAL/ NERVE DISORDERS			
PSYCHOLOGICAL/ PSYCHIATRIC			
RESPIRATORY/ BREATHING			
GASTROINTESTINAL			
GENITOURINARY			
EAR, NOSE, THROAT, MOUTH			
SKIN			
MUSCULOSKELETAL			
CANCER/IMMUNE SYSTEM			
OTHER MEDICAL			
EYE INFECTIONS			
EYE SURGERY			
EYE INJURIES			
OTHER			

ALLERGIES:

TO MEDICATIONS:_____

OTHER:_____

TOBACCO USE: YES NO PREVIOUSLY

IF YES: HOW MUCH?

ALCOHOL USE:

NEVER OCCASIONAL MODERATE DAILY

PEDIATRIC/BIRTH (IF APPLICABLE) PREMATURE?

YES NO IF YES, _____WEEKS

OXYGEN AT BIRTH? YES NO

PRIMARY CARE PHYSICIAN_____

OFFICE LOCATION_____

WOMEN ONLY: ARE YOU PREGNANT? YES NO

IF YES, HOW LONG?_____

ARE YOU NURSING? YES NO

I, the undersigned, agree to update this office with any changes that may occur with my health and/or use of medications. I have completed this form to the best of my knowledge.

X_____

DATE: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

(ALSO OVER THE COUNTER, VITAMINS, ETC.)

MEDICATIONS	FOR TREATMENT OF:
EYE DROPS	**HOW MANY/OFTEN**

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 health care 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 the office contact person at the address, fax or email shown at the beginning of this notice.
- 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 sending an email to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra costs. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax, or email shown at the beginning of this notice.
- 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. For the most part, however, you will be able to review or have a copy of your health information within thirty days of asking us (or sixty days if the information is stored off-site). 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 available. By law, we can have one thirty-day extension of time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax, or email shown at the beginning of this notice.
- 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 sixty days from when you ask us. We will send you 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 our 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 thirty 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 the office address, fax, or email shown at the beginning of this notice.
- get a list of the disclosures that we have made of your health information within the past six years (or shorter period if you want), by law the list will include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; required by law; 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 thirty-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office by address, fax, or email shown at the beginning of this notice.
- Get additional paper copies of this notice of privacy practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office, fax, or email shown at the beginning of the 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 as allowed by law. If we change this notice, the new privacy 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, have copies available in our office, and post it on our website.

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 the office by address, fax, or email 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 the office at the address or phone number shown above.

ACKNOWLEDGEMENT OF RECEIPT:

I acknowledge that I have read and/or received a copy of Johnson Eyecare's notice of privacy practices.

PATIENT NAME_____

PATIENT SIGNATURE_____

DATE_____/_____/_____

NOTICE OF PRIVACY PRACTICES
JOHNSON EYECARE
4622 PROGRESS DR. SUITE B
DAVENPORT IA 52807

PHONE: 563-345-6777 FAX: 563-345-6900
EFFECTIVE DATE OF NOTICE: JANUARY 1, 2006 EMAIL: JOHNSONEYECARE@YAHOO.COM

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS:

The most common reason why we use or disclose health information is for treatment, payment, or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing you glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Healthcare operations" means those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for healthcare operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION:

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 come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal food and drug administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence;
- uses and discloses for healthoversight activities, such as for the licensing of doctors, audits by Medicare or Medicaid, or for 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, 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 the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to workers compensation programs;
- disclosures of a "limited data set" for research, public health, or healthcare operations, incidental disclosures that are an unavoidable byproduct of permitted uses or disclosures; disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS:

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a postcard, and/or leave you a reminder message on your answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES: We will not make any other uses or disclosures of your health information unless you sign a written "authorization form". The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this notice.

Johnson Eyecare
4622 Progress Dr. Suite B
Davenport, IA 52807
563-345-6777

Please check any of the following which apply to you:

Have you ever been diagnosed with any of the eye following conditions?

- Cataract ☐
- Age-related Macular Degeneration ☐
- Glaucoma ☐
- Diabetes ☐
- Diabetic Retinopathy ☐
- Dry Eye ☐
- Eye infection, inflammation, or allergy ☐
- Floaters and/or flashes of light ☐
- Iritis or Uveitis ☐
- Retina defects or degenerations ☐

Any additional conditions:

Are you having any of the following concerns?

- Redness ☐
- Burning ☐
- Itching ☐
- Tearing ☐
- Discharge ☐

Additional Concerns:

Are you having any of the following vision concerns?

- Blurred Vision ☐
- Eyestrain ☐
- Eye Pain ☐
- Severe light sensitivity ☐
- Headache ☐
- Poor night vision ☐
- Bothersome night glare ☐
- Double vision ☐
- Total loss of vision ☐

Any additional concerns:

JOHNSON EYECARE

During a comprehensive eye exam our doctors need to evaluate the overall health of your eye. With the Optomap® Retinal Exam, we can screen for retinal complications including macular degeneration, glaucoma, and retinal holes or detachments.

This screening procedure can also detect systemic problems unrelated to the eye that may show signs in the retina such as diabetes, hypertension, cancer/tumors, auto-immune disorders, and others, earlier than possible with traditional methods. The optomap can also show cataracts, glaucoma, macular degeneration, and more. This is an optional part of the exam but HIGHLY recommended.

The Optomap® Retinal Exam:

- ✓ Is as fast as taking a picture
- ✓ DOES NOT REQUIRE DILATING DROPS. You may not need to be dilated today, potentially eliminating a 30-minute wait and avoiding side effects such as blurry vision and light sensitivity.
- ✓ Saved in your file enabling our doctors to make important comparisons during your annual eye exam.

There is a $30.00 charge for the Optomap® Retinal Exam. ($15.00 charge if under 18)

_____I understand that the Optomap® Retinal Exam will be performed today and do not have any questions.

Signature: _____ Date: _____/_____/_____