## WELCOME TO OUR OFFICE

*PATIENT ID:*

□ Dr. □ Mr. □ Mrs. □ Ms. _____ _____ _____
**Last Name** **First Name** Middle Name

Gender: □ Male □ Female Date of Birth: ___ __/_____/_____ _____ _____
**MM / DD / YY** **Age** Occupation

_____ _____ _____ _____
**Street Address** **Apt. #** **City** **State** **Zip Code**

_____ _____ _____
**Home Phone** **Business Phone –Cell Phone** **Email Address**

**Insurance Name: _____ ID #: _____ Group #: _____**
**Policy holder Name: _____SSN:_____ DOB: ___/___/_____**
**Patient's Relationship to Policy holder: Self / Child / Spouse / Other**

**REFERRAL** If you were referred by someone, whom may we thank? _____

### GENERAL EYE HISTORY *(Please check all that apply).*

| | Self | Family |
|---|---|---|
| Blur at distance with glasses or contacts | ❑ | |
| Blur at near with glasses or contacts | ❑ | |
| Blur at computer with glasses or contacts | ❑ | |
| Dry eye | ❑ | |
| Double vision | ❑ | |
| Lazy eye *(Poor vision even with correction)* | ❑ | |
| Eye injury | ❑ | |
| Eye surgery | ❑ | |
| Flashes | ❑ | |
| Floaters *(Little black dots or lines inside eyes)* | ❑ | |
| Glaucoma | ❑ | ❑ |
| Other _____ | ❑ | ❑ |
| None of the above | ❑ | ❑ |

Date of last eye exam: _____
What was the outcome of the exam: □ Glasses □ Contacts
□ No prescription needed □ Other _____

**Contact Lens History**
□ I would like to know my contact lens options
□ I am not interested in contact lenses.

### GENERAL HEALTH HISTORY

| | Self | Family |
|---|---|---|
| Headaches | ❑ | |
| Pregnant (if applicable) | ❑ | |
| High blood pressure | ❑ | ❑ |
| Cardiovascular disease | ❑ | ❑ |
| Diabetes | ❑ | ❑ |
| Lung disease | ❑ | |
| Hyperthyroidism | ❑ | |
| Hypothyroidism | ❑ | |
| Seasonal allergies | ❑ | |
| Drug Allergies | ❑ | _____ |
| Other _____ | ❑ | ❑ |
| None of the above | ❑ | ❑ |

Have you ever abused drugs or alcohol? □ Yes □ No
Do you smoke? □ Yes □ No
Please list any medications: _____

_____

## Retinal Scan -- Optos Optomap (no more dilation, no side effect)

Many eye problems can develop without you knowing, in fact, you may not even notice any change in your sight – fortunately, diseases or damage such as macular degeneration, glaucoma, retinal tears or detachments, and other health problems such as diabetes and high blood pressure can be seen with a thorough examination of the retina.

The **Optomap** is fast, easy, and comfortable for anyone. The entire image process consists of you looking into the device one eye at a time. The **Optomap** images are shown immediately on a computer screen so we can review it with you. This image becomes a part of your permanent medical record and enables us to see more of your retina, measure aspects of your eye, and magnify some of the finer details. We can also track changes in your eye over time by comparing each year's **Optomap** images. In addition, you take a more active role in your eye care by reviewing the images with your doctor and learning more about how best to protect your vision.

**The fee for Optomap images reviewed by your doctor is $30.00.**

□ **YES, I want Optomap images to be taken and reviewed.**

**Please Note: All fees paid for professional services are non-refundable and are payable at the time of the service. Patient/guardian authorizes that payment of medical and vision insurance be made to Dr. Julie Nguyen, PLLC for services provided. Patient is financially responsible for co-pay/deductible or any charges not paid by insurance.**

_____ _____
**Patient's signature (Parent or legal guardian if patient is under 18 years old)** **Date**

**DR. JULIE T. NGUYEN, PLLC**
**NOTICE OF PRIVACY PRACTICES**
**121 Highways 332 West, Ste 100. Jackson, TX 77566**
**Effective 1-1-2020**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION; THE "**OFFICE**" PERTAINS TO "**Dr. Julie Nguyen, PLLC**" PLEASE REVIEW IT CAREFULLY.

The office is required by law to maintain the privacy of your health information, to follow the items of this notice, and to provide you with this notice of our and privacy practices. We will not use or disclose medical information about you without your written authorization, except as described in this NOTICE. If your state law provides additional restrictions upon any of the forgoing uses and disclosures, we must follow your state law.

**How the Office May Use or Disclose Your Health Information**

- ***Treatment, Payment, and Regular Health Care Operations*** - Information obtained by the Office will be used to dispense and provide prescription ophthalmic goods and services to you, bill your insurance carrier if you have third party coverage, and to record and monitor the service provided to you. Information will also be provided to you upon your request.
- ***As and When Required by Law*** – We may use and disclose your health information to Public Health Officials, Health Oversight Activities (For audits, investigations, etc.), Judicial and Administrative, Deceased Person Information, Worker Compensation Programs, Food and Drug Administration (for reporting adverse drug events and quality issues), if there is a serious threat to your health or safety, in times of National Security, if you are in the Military or a Veteran of the armed forces, or if you become an inmate in a correctional facility.
- ***Personal Communications*** – We may contact you or individuals involved in your care or payment of your care to provide appointment reminders, annual eye examination cards and other information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- ***Disclosure to Our Business Associates*** – We may provide some services through contracts with business associates (accounting, etc.) When necessary, we may disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your health information, we require our business associates to appropriately safeguard your health information.
- ***Victims of Abuse, Neglect, or Domestic Violence*** – We may disclose your health to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

***Marketing Communications***. We must obtain your written authorization prior to using your health information to send you any general marketing materials. We may contact you about products or services relating to your treatment, care, or alternative treatments, or providers without prior authorization.

**Your Rights with Respect to Your Health Information**

- You have the right to request restrictions on certain uses and disclosures of your health information. The Office is not required to agree to the restriction that you requested.
- You have the right to inspect and copy your health information (prescription, billing records, etc.) as long as the Office maintains the health information. To inspect or copy your health information, you must submit a written request to the location that provided your services. We may charge you a fee for the cost of copying, mailing, or other supplies that are necessary to grant your request. We may deny your request to inspect and copy under certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed. You have the right to request that the Office amend your health information that is incorrect or incomplete. The office is not required to change your health information and will provide you with information about the procedure for addressing any disagreement with the denial.
- You have the right to receive an accounting of disclosures of your health information we have made since August 2, 2008 for most purposes other than treatment, payment, health care operations provided to you, and certain government functions. You must specify the time period but be no longer than six years. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time.
- You may request communications of your health information by alternative means or at alternative locations. For example, you may request that we contact you about medical matters or at a different residence or post office box. Your request must state how or when you would like to be contacted. We will accommodate all reasonable requests.

If you would like to exercise one or more of these rights, need additional information, or believe your privacy rights have been violated, contact the location that provided your services at the address above. There will be no retaliation.

**Changes to this Notice of Privacy Practice**

The Office reserves the right to amend our practices and this Notice of Privacy Practices at any time in the future and to make the new Notice effective for all medical information we maintain. Until such amendment is made, the Office is required by law to comply with this Notice.

- I have read and authorized the disclosure of my health information as described on this form.

**Patient's/Guardian's signature: _____ Date: _____**