# PATIENT INFORMATION RECORD

**PATIENT INFORMATION For CHILD (Please Print)**

| Patient Name (First, MI, Last) | Sex M F | Marital Status NM M W D SEP | Date of Birth |
|---|---|---|---|
| Address (including City, State, Zip Code) | | | Social Security Number |
| Email | Home Phone | Cell Phone | Work Phone |
| Preferred Contact for Appointment Reminders (please check) Call Home ☐ Cell ☐ Work ☐ Email ☐ | | | |

| Emergency Contact | Emergency Contact Relationship | Emergency Contact Phone |
|---|---|---|
| Does the Child have the following? | Power of Attorney | |

## INSURANCE INFORMATION

| Do You Have Insurance? Yes No IF YES, PLEASE PRESENT INSURANCE CARD AT RECEPTION | | |
|---|---|---|
| Primary Policy Holder | Date of Birth | Relationship |
| Insurance Name | Policy Number | Group Number |
| Secondary Insurance Policy Holder | Date of Birth | Relationship |
| Insurance Name | Policy Number | Group Number |

## FOR MINOR OR STUDENTS, PLEASE FILL INFO BELOW

| Mother's Name | Date of Birth | Social Security Number |
|---|---|---|
| Address (including City, State, Zip Code) same as above ☐ | Occupation | Contact Number same as above ☐ |
| Father's Name | Date of Birth | Social Security Number |
| Address (including City, State, Zip Code) same as above ☐ | Occupation | Contact Number same as above ☐ |

# Ho Vision Group

Neuro-Optometric Physician

### 1) Authorization for Optometric Services and Assignment of Insurance Benefits

I hereby authorize Dr. Jamie Ho to examine, diagnose, treat, and manage my eye health and visual conditions as necessary. I hereby assign all health insurance benefits Ho Vision Group for services rendered. This assignment includes benefit programs of which I am a beneficiary. I authorize the release of all information from all sources necessary to secure payment for service rendered. The benefits/funding outlined above have been explained to me. I am aware and understand that this does not guarantee services will be reimbursed as outlined.
Please also note that if a referral is required for your insurance to see a specialist, it is your responsibility to have that at your time of visit.

I understand that I am responsible for payment of charges not covered by my insurance including copayments, coinsurance, and unmet deductibles which are due at time of service. *Refractions when performed are a non covered service by medical insurance and are due at the time of service. The fee for refraction is $85.00.*

Any returned checks will be charged a $30.00 fee, and a 30% return fee will be applied to any eyeglasses, contact lenses, and/or non-prescriptive low vision aids that are ordered then cancelled by the patient. Any patient who fails to show for an appointment and has not contacted our *office* prior with at least 24 hours notice will be considered a *No Show* and charged a $30.00 *fee.*

### 1) Parental/Guardian Authorization for Treatment of a Minor

Mother / Father/ Guardian's Name_____

I am the parent/legal guardian of _____ and have the power to authorize Dr. Ho to examine, diagnose, treat, and manage the eye health and visual conditions of my child as deemed necessary. I have also read the above paragraphs "Authorization for Optometric Services and Assignment of Insurance Benefits" and agree to the terms listed therein.

_____

Parent/Guardian Signature Date

### 2) Disclosure of Health Information and Release of Medical Records

I hereby authorize the release and use of my or my child's health information, medical, and/or billing records to the physicians, hospital, clinics, third party payors, teachers, special educators, or others as I may direct. These records include but are not limited to examinations and progress notes, fundus photographs, retinal angiograms, ultrasonography, reports, visual field charts, and all other medical and financial information pertinent to my previous health care. It is customary for our practice to send a summary report of examination findings to the patient's referral source if applicable.

_____

Patient/Responsible Party Signature Date

# Ho Vision Group

## HIPPA SHORT FORM NOTICE OF PRIVACY PRACTICES

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

**We are required by law to:**

- Make sure that health information that identifies you is kept private
- Give you this Notice of our legal duties and privacy practices with respect to health information about you; and/or your child
- Follow the terms of the Notice that is currently in effect.

**How we may use and disclose health information about you:**

- For treatment
- For payment
- For health care operations
- For appointment reminders
- To avert a serious threat to health and safety
- National Security and Intelligence activities
- Coroners, health examiners and funeral directors
- Protective Services for the President and others
- As required by the Military or Veterans and Workers Compensation
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- As required by Law
- Security Officials for Inmates

**Your rights regarding Health Information about you:**

- Right to an Accounting of Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communications
- Right to a Paper copy of this Notice (**The long full HIPPA Policy is available upon request**)
- Right to Inspect and copy
- Right to Amend

- <u>There have no changes to individuals authorized to have access to appointments, scheduling, and my medical information since the last HIPPA form I have signed.</u>

**Acknowledgement of Receipt of this Notice:**

_____ _____

Patient Guardian Signature Date

_____ _____

Patient Name Printed Authorized Provider Representative

## Communication Information:

How would you prefer that we get in touch with you? ☐ Telephone ☐ Email ☐ Mail

**Due to the Privacy Act**, I hereby give permission **(unless initialed "NO")** for Politzer and Ho Vision Group to leave a voice mail or recorded message (NO___), send emails concerning appointments and billing (NO___), speak with spouse or family member concerning appointment (NO___), medical condition (NO___), or billing inquiries (NO__).

**I authorize you to speak to the named below concerning appointments, medical conditions, etc. as well as any provider I am referred by or to.**

| Name | Relationship | Street Address, City, State, Zip Code | Phone No. |
|---|---|---|---|
| Name | Relationship | Street Address, City, State, Zip Code | Phone No. |
| Name | Relationship | Street Address, City, State, Zip Code | Phone No. |

## Demographic Information:

Preferred Language
- ☐ English
- ☐ Spanish
- ☐ French
- ☐ Japanese
- ☐ Vietnamese
- ☐ Decline to specify

Race:
- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Black / African American
- ☐ Hispanic
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ White
- ☐ Decline to specify

Ethnicity:
- ☐ African American
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic or Latino
- ☐ Not Hispanic of Latino
- ☐ Other Pacific Islander
- ☐ Decline to specify

## Referral Information: How did you hear about our office?

| | Name of Referral/Website | Referral Information (Phone/Address) |
|---|---|---|
| One of Our Patients | | |
| Internet | | |
| Professional Referral | | |
| Other | | |

# PATIENT HEALTH QUESTIONNAIRE

**CHILD'S NAME**_____ **DATE of BIRTH**_____ **DATE**_____

**CURRENT HEALTH:**

Does your child take any medications regularly? Yes No

If yes, please list: _____

_____

_____

Does your child have any allergies to food, or medicine? Yes No

If yes, please list _____

_____

**Social History**

| | | Date Started | Quantity / Type / Frequency |
|---|---|---|---|
| | Tobacco Use | | |
| | Narcotic Use | | |
| | Alcohol Use | | |
| | Blood Transfusion | | |

## CURRENT and PAST HEALTH

Has your child been diagnosed or experienced any of the following conditions?

| | | | | | |
|---|---|---|---|---|---|
| | Heart Disease/TIA | | Arthritis | | Diabetes |
| | High Blood Pressure | | Crohns / IBS | | Thyroid Disease |
| | Vascular Disease | | Rosacea | | Bleeding Disorder |
| | Stroke/CVA | | Multiple Sclerosis | | Cancer |
| | Asthma/Emphysema | | Seizures | | Sexually Transmitted Disease |
| | Kidney Disease | | Headaches / Migraines | | Lazy Eye / Strabismus |
| | Liver Disease | | Neurological Diseases | | Learning Disabilities |
| | Prostate Disease | | Psychiatric Conditions | | Other: |

**CHILD'S NAME**_____ **DATE of BIRTH**_____ **DATE**_____

**Please list all previous surgeries including eye surgeries.**

| Date | Type of Surgery | Doctor and/or Hospital |
|---|---|---|
| | | |

**Does your child currently use or wear any of the following?**

| | | | | | |
|---|---|---|---|---|---|
| | Wear Glasses | | Wear Contact Lenses | | Hand Telescopes/Magnifiers |

**Please check any of the conditions your child is currently being affected by.**

| | | | | | |
|---|---|---|---|---|---|
| | Blurry Vision | | Dry Eyes | | Headaches |
| | Fluctuating Vision | | Itchy Eyes | | Reading Difficulties |
| | Vision Loss | | Burning Eyes | | Ocular Fatigue |
| | Distorted Vision | | Gritty/Sandy Sensation | | Balance Difficulty |
| | Double Vision | | Flashing Lights | | Frequent Falls |
| | Squinting | | Floaters | | Bumping into Objects |
| | Light Sensitivity | | Eye Pain | | Other: |
| | Lazy Eye / Amblyopia | | Eye Redness | | |

## FAMILY HEALTH

**Does your child have any blood relatives have any of the following conditions?**

| | | Relationship | | | Relationship |
|---|---|---|---|---|---|
| | Glaucoma | | | Diabetes | |
| | Macular Degeneration | | | Hypertension | |
| | Retinal Detachment | | | Heart Disease | |
| | Poor Vision / Low Vision | | | Stroke | |
| | Amblyopia / Strabismus | | | Cancer | |
| | Other Eye Conditions | | | Neurologic Disease | |
| | | | | Other Systemic Conditions | |

**CHILD'S NAME_____ DATE of BIRTH_____ DATE_____**

Your Child was delivered at _____weeks and was _____lbs____oz.

| | Yes | No | If Yes, Please explain |
|---|---|---|---|
| Were there any problems during your pregnancy/delivery? | | | |
| Were there any problems immediately following delivery? | | | |
| Has your child been diagnosed with a birth defect? | | | |
| Has your child been diagnosed with a learning disability or behavior disorder? | | | |
| Does your child have any speech difficulty? | | | |
| Were there any delays in Fine/ Gross motor development? | | | |

**Visual History**

| | Yes | No | If Yes, Please explain |
|---|---|---|---|
| Has your child ever worn glasses/contacts? | | | |
| Has your child ever worn an eye patch? | | | |
| Does your child complain of tired or painful eyes? | | | |
| Does your child complain of seeing double? | | | |
| Does your child close or cover one eye? | | | |
| Does your child blink excessively? | | | |
| Does your child complain of headaches/ dizziness/ nausea when reading? | | | |

**If your child attends school please complete the following**

What grade is your child currently in? _____ What School does your child attend? _____

Teacher's Name_____ Vision Teacher / School Therapist Name _____

| | Yes | No | If Yes, Please explain |
|---|---|---|---|
| What is your child's easiest subject? | | | |
| What is your child's hardest subject? | | | |
| Does your child reverse letters or numbers when reading/writing? | | | |
| Does your child skip letters or lines when reading? | | | |
| Does your child reread lines or words? | | | |
| Does your child move their head when reading? | | | |
| Does your child use their finger to follow words? | | | |
| Does your child hold books close when reading? | | | |
| Has your child had to do any remedial work? | | | |
| Has your child ever had a visual screening? | | | |
| Does your child receive any special education or IEP? | | | |
| Does your child have poor reading comprehension? | | | |
| Does your child have trouble copying from the board? | | | |
| Does your child have a loss of concentration? | | | |