

Q VISION[®]
PATIENT MEDICAL HISTORY

Name: _____ DOB: _____ Age: _____ Today's Date: _____

1. Please list any medication allergies you have or circle none: _____ none

2. Do you take any of the following medications? (Check all that apply.)

- Accutane / isotretinoin (acne)
 Imitrex / sumatriptan (or similar migraine headache medication)
 Cordarone / amiodarone (heart)
 None of the above

3. Please list any other medications you take or circle none: _____ none

4. Do you have a history of any of the following eye disorders? (Check all that apply.)

- Corneal trauma, scar, surgery, disease or disorder
 Herpes keratitis
 Keratoconus
 Cataract
 Retinal detachment
 Glaucoma
 Amblyopia / lazy eye
 Strabismus / squint
 Dry eye
 None of the above Other: _____

5. Does anyone in your family have keratoconus? No Yes

6. If applicable, are you currently pregnant, planning on becoming pregnant or nursing?

- Yes, pregnant
 Yes, nursing
 Yes, planning on becoming pregnant
 No / not applicable

7. Do you have a history of any of the following medical problems? (Check all that apply.)

- Seizures
 Pacemaker
 Diabetes
 Arthritis
 Thyroid disorder
 Lupus
 Scleroderma
 Dermatomyositis
 None of the above

8. Please describe any other problems or medical conditions here:

Signature: _____



LASER VISION CORRECTION PATIENT INFORMATION

Patient Name: (Last) _____ (First) _____ (MI) _____

Birth Date: _____ Age: _____ Male / Female

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Summer Address: (if applicable) _____

City: _____ State: _____ Zip: _____

Summer Phone: _____ Summer Work: _____

E-mail Address: _____

Who should we contact in case of emergency? _____

Their phone number: _____ Their relationship to you: _____

Who is your family physician: _____ Phone: _____



HIPAA NOTICE OF PRIVACY PRACTICES

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.

This Notice of Privacy Practices describes how we use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support, the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of patient: _____

Date: _____