

Welcome To Our Office

Hoffman Optometry

Patient Information	Acknowledgment of Receipt of Privacy Practices
<p>PLEASE PRINT Date: _____</p> <p>Name: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip _____</p> <p>Date of Birth: _____</p> <p>Telephone: Home: _____</p> <p style="padding-left: 100px;">Work: _____</p> <p>OK to TEXT? ____ Cell: _____</p> <p>Email: _____</p> <p>Communication Preferred: HOME CELL WORK <small>Circle all that apply</small></p> <p>Who may we thank for referring you? _____</p> <p>Employer: _____</p> <p>Occupation: _____</p> <p>Name of Spouse: _____</p>	<p style="text-align: center;"><u>2390 E. Bidwell Suite #400</u> <u>Folsom, CA. 95630</u> <u>Phone:(916) 983-6211 Fax:(916) 983-6608</u></p> <p>Signing this document signifies that you have received a copy of our Notice of Privacy Practices</p> <p>In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct healthcare operations involving our office. The notice of Privacy Practices you have been given describes these uses and disclosures in detail.</p> <p>I acknowledge that I have received the Notice Of Privacy Practices.</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 45%; text-align: center;"> <p>_____</p> <p>Signature</p> </div> <div style="width: 45%; text-align: center;"> <p>_____</p> <p>Date</p> </div> </div> <p>If signing as a personal representative of a patient, describe the relation to the patient and the source of authority to sign this form:</p> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%; text-align: center;"> <p>_____</p> <p>Relationship to Patient</p> </div> <div style="width: 45%; text-align: center;"> <p>_____</p> <p>Print Name</p> </div> </div> <div style="margin-top: 10px;"> <p>_____</p> <p>Source of Authority</p> </div>

Insurance Information	Our Payment Policy
<p>Subscriber Name: _____</p> <p>Subscriber's Employer: _____</p> <p style="padding-left: 40px;">Date of Birth: _____</p> <p style="padding-left: 40px;">last 4 of SS#: _____</p> <p style="padding-left: 40px;">Identification #: _____</p> <p>Relationship to Patient: _____</p> <p>Vision Insurance: Please Circle: VSP MES EyeMed Superior Davis Spectera/Optum Other: _____</p>	<ol style="list-style-type: none"> 1. Payment in full is due at the time of Services 2. A \$25 service charge on all returned checks. 3 Insurance Policy: Regardless of any insurance coverage, the total balance due is the legal responsibility of the patient. Payment not received with in 60 days will be the patient's responsibility. 4. I have read and understand the above policies. <p>Signature: _____</p>

Medicare Authorization	
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I request that payment of authorized medicare benefits be made to me or on my behalf to Robert A. Hoffman / Lianne C. Inouye offices for any and all services.

To the extend permitted by law, I authorize any holder of medical or other information about me to be released to the Center for Medicare Services and their agents (any related information to determine these benefits will be provided).

Signature of Beneficiary, Guardian or Representative:

Please print name of beneficiary, Guardian or Representative

Patient Medical and Eye History

What is the purpose of today's visit? _____

Date of Last Medical Exam: _____

List any Major Surgeries: _____

Date of Last Eye Exam: _____

Are you pregnant or nursing: **YES NO**

Allergies to Medications: YES NO	Currently taking Medications: YES NO	
If yes, please list: _____ _____ _____	If yes, please list: _____ _____ _____	
Do you currently have or have you had any of the following:	Do you currently have or have you had any of the following:	Do you currently have or have you had any of the following:

Blurred Vision	NO	YES	Eye Pain	NO	YES	Emphysema	NO	YES
Loss of Vision	NO	YES	Chronic eyelid infections:	NO	YES	Diabetes	NO	YES
Distorted Vision	NO	YES	Styes or Chalazion	NO	YES	Heart disease	NO	YES
Loss of side Vision	NO	YES	Light flashes	NO	YES	High blood pressure	NO	YES
Double Vision	NO	YES	Tired eyes	NO	YES	Vascular disease	NO	YES
Red Eyes	NO	YES	Thyroid disease	NO	YES	Diarrhea or constipation	NO	YES
Dry Eyes	NO	YES	Allergies or hay fever	NO	YES	Kidney or bladder disease	NO	YES
Mucous discharge	NO	YES	Chronic cough	NO	YES	Rheumatoid arthritis	NO	YES
Sandy or gritty feeling:	NO	YES	Dry mouth	NO	YES	Joint pain	NO	YES
Itchy eyes	NO	YES	Asthma	NO	YES	Bleeding problems	NO	YES
Foreign body sensation	NO	YES	Chronic bronchitis	NO	YES	Depression or anxiety	NO	YES

Please list family history for the following conditions:

			Relationship				Relationship
Cataracts	YES	NO	_____	Diabetes	YES	NO	_____
Glaucoma	YES	NO	_____	Cancer	YES	NO	_____
Macular Degeneration	YES	NO	_____	Heart Disease	YES	NO	_____
Retinal Detachment	YES	NO	_____	High Blood Pressure	YES	NO	_____
Crossed eyes	YES	NO	_____	Thyroid disease	YES	NO	_____
Blindness	YES	NO	_____	Other: _____			_____
Arthritis	YES	NO	_____				_____
Lupus	YES	NO	_____				_____

Do you currently use or have you ever used any of the following:	Have you been exposed to or infected with any of the following:
Tobacco products YES NO	Gonorrhea YES NO
Alcohol YES NO	Hepatitis YES NO
Illegal Drugs YES NO	Syphilis YES NO
Other: _____	HIV YES NO
Would you like to talk to the doctor concerning these issues?	Would you like to talk to the doctor concerning these issues?
YES NO	YES NO

Have you had any previous eye surgery?	NO YES _____	Have you had any previous eye injuries	_____
Previously had your eyes dialated?	NO YES _____	If yes, any significant side effects?	_____
Do you have blurred vision?	NO YES _____	If yes, distance: (circle) FAR CLOSE BOTH	_____
Do you currently wear contacts?	NO YES _____	If yes, what brand reason:	_____

Attestation

I have read and understand, to the best of my knowledge, the above information. I certify that all statements are truthful and accurate. I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I understand that I am financially responsible for any service considered non-covered, any deductibles and/or co-payments as well as any service denied due to non-participating provider.

Patient/Parent/Guardian Signature

Date