NEW YORK CORNEA CONSULTANTS

Name: _____ Today's Date: ____/____/20__

Address: _____ Phone: _____ _____

_____

Birth Date: ___/___/___ Social Security #: _____/_____/_____ Last Eye Exam ____/____/____

Name of Medical Doctor: _____ Last Medical Exam ____/____/____

Doctor's Phone: _____ _____

Medical History

Do you have any allergies to medications? ☐ no ☐ yes If yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Circle any of the following that **you** have had: crossed eyes lazy eye drooping eyelid prominent eyes
glaucoma retinal disease cataracts eye infections/ injury

Are you pregnant or nursing? ☐ no ☐ yes
Do you wear glasses? ☐ no ☐ yes If yes, how old is your present pair of lenses? _____
Do you wear contact lenses? ☐ no ☐ yes If yes, how old is your present pair of lenses? _____
Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other _____
Are they comfortable? ☐ no ☐ yes
Have you had vision surgery? ☐ no ☐ yes If yes, which? RK PRK LASIK INTACS Ortho-K other _____

Family History

Please note any family history (**parents, grandparents, siblings, children**; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other		☐		_____

*** Please complete page two ***

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

1. **Marital Status:**
   - Married
   - Legally separated
   - Divorced
   - Widowed
   - Partner
   - Single

2. **Employment:**
   - Full-Time student
   - Part-Time student
   - Employed
   - Unemployed
   - Self employed
   - Retired
   - Active military

3. **Smoking Status:**
   - Current every day smoker
   - Current some day smoker
   - Former smoker
   - Never smoker

4. **Ethnicity:**
   - Hispanic/Latino
   - American Indian/Alaska Native
   - Asian

5. **Race:**
   - Black /African American
   - White/Caucasian
   - Native Hawaiian/Other Pacific Islander
   - Other

6. **Preferred Language :**
   - English
   - Spanish
   - Russian
   - Creole
   - Other

7. **Email Address:**
   - _____

8. **Pharmacy information:**
   - _____
     _____
     _____

9. **Falls Risk (> 65yrs of age):**
   - Have you fallen in the last 12 months ? YES NO

10. **Patients with Diabetes:**
    - Last time you tested your Hemoglobin A1c ? _____

11. **PSA (Men >40 yrs of age):**
    - Have you been tested ? YES NO

12. **Colonoscopy (>50 yrs of age):**
    - Have you been tested ? YES NO

HIPPA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and AccountabilityAct of 1996(HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

~Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.

~Obtain payment from designated third-party payers.

~Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information(available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abound to abide by such restrictions.

I understand that I amy revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

_____ _____

Patient's Name DOB: (mm/dd/yy)

_____ _____

Signed (Patient or Legal Representative for Patient) Date

_____

Legal Representative's Relationship to Patient