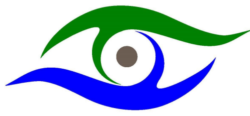


El Dorado Hills Vision Center Optometry

3955 Park Dr. Suite 1, El Dorado Hills, CA 95762 (916) 292-5666 **Kambiz Khorram, OD**

WELCOME TO OUR OFFICE! Please complete this form as accurately as possible.

Male Female ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Last Name ______________ First ______________ Birthdate ______________

Middle Initial(s) ______________ Nickname ______________

Mailing Address ______________

City ______________ State ______________ Zip ______________

Home Phone ______________ Work Phone ______________ Cell Phone ______________ Texting Ok? ☐ Yes ☐ No

E-mail ______________ Preferred method of contact: ☐ Email ☐ Postal ☐ Phone

Employer (Or School) ______________ Occupation (Or Grade) ______________

Marital Status ______________ Name of Spouse ______________

Name of Responsible Person of Account ______________ Relationship ______________

Emergency Contact: ______________ Relationship ______________ Phone ______________

Referred By: ______________

INSURANCE INFORMATION (Write "None" if no insurance)

	Company	Subscriber	Membership #
Primary Vision Insurance			
Second Vision Insurance			
Primary Medical Insurance			

Patient EYE History

Reason For Visit : ☐ Check Up *(No Difficulty, Seeing Clearly And Comfortably)*
☐ Seeing Or Eye Problem *(Please Explain)* ______________

How Long Ago Was Your Last Complete Eye Exam? ______________ Dilated ☐ Yes ☐ No

Who Was Your Last Eye Doctor? ______________ Who Is Your Primary Care Physician? ______________

Do You Wear Glasses? ☐ Yes ☐ No How Old Are Your Present Glasses? ______________

Are you interested in glasses for: Distance Near Computer Sports Sunglasses

Have you had problems with prior glasses: ______________

Have You Ever Worn Contact Lenses? ☐ Yes ☐ No

Do You Currently Wear Contact Lenses? ☐ Yes ☐ No ☐ Sometimes

State Contact Lens Type (Brand, Base Curve, Diameter, Power) ______________

Rate how your conact lenses feel immediately after **first** put them in.

Poor *Excellent*

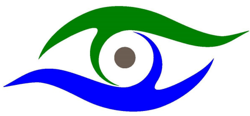
Rate how your conact lenses feel **just before** you take them out.

Poor *Excellent*

If No, Are You Interested In Wearing Contact Lenses? ☐ Yes ☐ No ☐ Maybe

Have You Ever Had Any Eye Disease, Eye Injury, Or Eye Surgery? ☐ Yes ☐ No *(If Yes, please describe)*

____



Patient HEALTH History

Dr. Kambiz Khorram

Name

Do you or Anyone in Your **Immediate** Family Have Any History of the Following? If yes, please check the box.

Glaucoma	☐ Self	☐ Family
Cataract	☐ Self	☐ Family
Macular Degeneration	☐ Self	☐ Family
Retinal Detachment	☐ Self	☐ Family
Red Eyes	☐ Self	
Dry Eyes	☐ Self	
Watery Eyes	☐ Self	
Eye Injuries	☐ Self	
Itchy Eyes	☐ Self	

Heart Disease	☐ Self	☐ Family
High Blood Pressure	☐ Self	☐ Family
High Cholesterol	☐ Self	☐ Family
Respiratory	☐ Self	☐ Family
Neurological	☐ Self	☐ Family
Gastrointestinal	☐ Self	☐ Family
Cancer	☐ Self	☐ Family
Allergy	☐ Self	

Thyroid	☐ Self	☐ Family
Arthritis	☐ Self	☐ Family
Headache	☐ Self	☐ Famiy
Lupus	☐ Self	☐ Famiy
Kidney	☐ Self	☐ Family
Diabetes	☐ Self	☐ Family

Pregnant/Nursing Yes No

Are You Currently Taking Any Drugs Or Medications?
Yes No *(If Yes, please list)* ______________________________

____

Are You Allergic To Any Drugs Or Medications?
Yes No (If Yes, please list) ______________________________

____

Do You Currently Smoke? Yes No Have You Ever Smoked Before? Yes No Height ___________
Do You Drink Alcohol? Yes No Do You Use Recreational Drugs? Yes No Weight ___________

I authorize the release of any medical information necessary to process any claims(s) to my insurance company, social security administration, or any of the above named insurances. I request all payments under the insurance program be made to me or to the provider for services and materials furnished to me during the effective period of this authorization. This assignment will remain in effect until revoked by me in writing.

I understand that I am financially responsible for all charges incurred and in the event that insurance payments are sent directly to me, I will remit payment to this office. If my insurance does not pay all bills submitted, I acknowledge that these bills are my responsibility and will guarantee payment. I further agree to pay any reasonable cost, including attorney and collection agency cost, in the event my account becomes delinquent.

I ACKNOWLEDGE THAT I RECEIVED A COPY OF EL DORADO HILLS VISION CENTER OPTOMETRY'S NOTICE OF PRIVACY PRACTICES.

______________________ ______________________ ______________

Print Name (patient or parent/guardian) Patient Signature (or parent/guardian) Date

Copy of the El dorado Hills Vision Center Optometry Notice of Privacy is On The Next Page.

NOTICE OF PRIVACY PRACTICE

THIS NOTICE OF PRIVACY IS PROVIDED FOR EDUCATIONAL AND INFORMATIONAL PURPOSES ONLY.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIIS NOTICE IS EFFECTIVE UNTIL FURHER NOTICE.

Right to Notice: As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPAA), El Dorado Hills Vision Center Optometry can use your protected health information for treatment, payment and health care operations. A) Treatment - We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. B) Payment - We may use and disclose your health information to obtain payment for services we provide you. C) Health care operations- We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: Most uses and disclosures that do not fall under treatment, payment, health care operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations: In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare,

Marketing: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may also use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety.

National Security: We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter.

Your Rights as a Patient: You have the right to restrict tile disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or health care operations. You have the right to receive confidential communications regarding your protected health information. You have the right to inspect and copy your protected health information. You have the right to amend your protected health information. You have the right to receive an account of disclosures of your protected health information. You have the right to a paper copy of this notice of privacy practices.

Legal Requirements: El Dorado Hills Vision Center Opotmetry is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted to this site, or are available within our office.

Complaints: If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office.