RECEIPT OF NOTICE OF PRIVACY PRACTICES As a patient of Amerine Eye Care, I recognize that I may receive the most current copy of the Notice of Privacy Practices for my records. I understand that, under HIPPA regulations, I am required to receive this Document to keep if I wish. I also understand that any changes will be brought to my attention on the next appointment or sooner if applicable. I also understand that it is my responsibility to read this document and contact Amerine Eye Care should I have any questions regarding the policies outlined in this notice.

AUTHORIZATION FOR ACCESS TO PERSONAL INFORMATION The undersigned patient of Amerine Eye Care hereby authorizes any member of his staff or agent and Optometric Physicians filling in for him on both a temporary or regular basis to have access to any and all of my patient records including but not limited to, the examination records (including my name, address, age, telephone numbers, wireless telephone numbers, email address) and findings and pertinent facts discovered and disclosed during the course of such examination, as well as the record of any professional services rendered and fees charged. You agree, in order for us to service your account or to collect any amounts you may owe us we may use all methods of contact include using a pre-recorded /artificial voice and/or the use of an automated dialing device, and/or text messaging which could result in charges to you. I have read this disclosure and agree that your clinic or agent may contact me as described above.

INSURANCE STATEMENT–As a courtesy to you, we may file your insurance for professional services to include but not limited to examinations, diagnostic testing, and materials provided. For any reason that your insurance company should not cover your total professional service, you will be responsible for the remaining balance within 30 days. Amerine Eye Care representatives are not authorized to negotiate with your insurance company for payment of professional services.

MATERIALS PICK UP (Must present valid State ID/DL) I authorize the below listed access to pick up glasses, contacts, and or my personal records on my behalf. I understand that anyone other than the below listed will be denied any and all access. I acknowledge that this authorization may be revoked at any time with a written submission statement

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

PAYMENT INFORMATION: Select your payment method today:

___ Cash ___ Visa/MasterCard /Discover/ American Express _____ Pre-Printed Personal Check (AR ID Required)
Circle One

RECALL PREFERENCE: Select the method you wish us to contact you for prescription expirations and appointment reminders. All medical follow ups will be pre-appointed.

_____ Post Card _____ Email _____ SMS Text Message

ACKNOWLEDGEMENT OF COMPLETION I have read and carefully reviewed these documents to the best of my ability.

Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date

DATE:_____

Amerine Eye Care

PATIENT INFORMATION Legal Name: _____ Gender: M / F
Circle One

SS#: _____-_____-_____ DOB: _____ Age: _____ Primary Phone: (_____) _____ Mobile / Home
Circle One

Address:_____
Street Address Apt No. City State Zip Code

Email:_____ Alternative Phone:(_____) _____Mobile / Home
Circle One

Medical Doctor: _____(_____)_____ Last Medical Exam:_____
Primary Care Physician Name Office Telephone Number

Occupation: _____ Employer: _____Phone: (_____) _____

Employer Address:_____

GUARDIAN/INSURANCE POLICY HOLDER Complete if under 18 years & for primary insurance policy holders.

Name: _____ Relationship:_____ DOB:_____
First M.I. Last

SS#: _____ Phone:(_____)_____ Email:_____

INSURANCE–List your insurance information and present your insurance card(s) & DL/ID for photocopying. Be sure to list the Policy Holder in the section above.

Medical Insurance- Many conditions such as floaters, dry eyes, itchy eyes, cataracts, diabetes & more may be billed under your major medical insurance.

Insurance Name: _____ID: _____

Vision Insurance- Healthy eyes without any ocular diagnosis or concerns may be billed under your vision insurance.

Insurance Name: _____ID: _____

REVIEW OF SYSTEMS A comprehensive health history allows us to better assess your eye overall eye health.

For the remaining sections **Check Y (Yes) or N (No)** if any of the following are current or chronic conditions.

FAMILY MEDICAL HISTORY: For the following conditions please review and indicate which family member is being treated. (Family is defined as parents, grandparents, siblings, or children either living or deceased).

Y N	Relationship	Y N	Relationship
☐☐ Glaucoma	_____	☐☐ Blindness	_____
☐☐ Cataract	_____	☐☐ Cancer	_____
☐☐ Lupus	_____	☐☐ Diabetes	_____
☐☐ High Blood Pressure	_____	☐☐ Heart Disease	_____
☐☐ Macular Degeneration	_____	☐☐Crossed Eye	_____
☐☐ Thyroid Disease	_____	☐☐ Retinal Disease	_____
☐☐Retinal Detachment	_____	☐☐ Other:	_____
☐ I am adopted		☐ I do not know my family history	

SOCIAL HISTORY:

HOBBIES: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed **Sexual History**: □ Active □ Non-active □ Decline to Respond

Completed Education: □ High school/Equivalent □ Vocational/Trade □ College Degree □ Other_____

Tobacco Use: ☐ No ☐ Yes How Much _____ Years Usage _____ Method: Vaping/ E-Cig, Cigarettes, Smokeless
Alcohol Use : ☐ No ☐ Yes How Much _____ Years Usage _____ Circle Method(s)
Illegal Drugs: ☐ No ☐ Yes How Much _____ Years Usage _____

ALLERGIES: list any medication(s) or other allergies (ie. Latex or food) ☐ NO KNOWN ALLERGIES

CURRENT MEDICATIONS: The following medications may affect your eye health.

Y N	Y N	Y N
☐☐Amiodarone (Pacerone,Cordarone)	☐☐Chlorpromazine (Thorazine)	☐☐Choloroquine (Aralen)
☐☐Digoxin (Lanoxin)	☐☐Ethambutol (Myambutol)	☐☐Hydroxychlorquine (Plaquenil)
☐☐Indomethacin (Indocin)	☐☐Lithium (Eskalith,Lithoid)	☐☐Methotrexate (Rheumatrex)
☐☐Rifampin (Rifadin)	☐☐Tamoxifen (Nolvadex)	☐☐Thioridazine (Mellaril)
☐☐Trifluoperazine (Stelazine)	☐☐Ziprasidone HCL	☐☐Isonicotinic Acid Hydrazide (Izoniazid)

Provide or list all other medication including name/dosage/frequency/route of administration (include oral contraceptives, aspirin, over the counter medications and home remedies) ☐ NO MEDICATIONS

Name_____ Dosage_____ Frequency _____ Route/Administration _____

Name_____ Dosage_____ Frequency _____ Route/Administration _____

Name_____ Dosage_____ Frequency _____ Route/Administration _____

Name_____ Dosage_____ Frequency _____ Route/Administration _____

Name_____ Dosage_____ Frequency _____ Route/Administration _____

Have you had a flu shot this season? ☐ No ☐ Yes If Yes, Date _____

PERSONAL MEDICAL HISTORY current or chronic history of the following:

Y N	Y N	Y N	Y N
☐☐ Anemia (H)	☐☐ Pre-Hypertension (CV)	☐☐ Osteoporosis (M)	☐☐ High Cholesterol (H)
☐☐ Multiple Sclerosis (N)	☐☐ High Blood Pressure	☐☐ Cardiac Arrhythmia (CV)	☐☐ Allergies (A/I)
☐☐ Migraines/ Headaches (N)	Last BP _____ Date _____	☐☐ Skin Problems (I)	☐☐ Lupus (A/I)
☐☐ Psychiatric	☐☐ Diarrhea/Constipation (GI)	☐☐ Bronchitis (R)	☐☐ Emphysema
☐☐ Cancer (C) _____	☐☐ Pulmonary Disease (R)	☐☐ Colitis (GI)	☐☐ Diabetes (E) 1/ 2/ G/ P
☐☐ Sinus Problems (ENT)	☐☐ Seizures (N)	☐☐ Kidney Disease (GU)	☐☐ Thyroid Dysfunction(E)
☐☐ Hearing Loss (ENT)	☐☐ Vascular Disease (CV)	☐☐ Rheumatoid Arthritis(M)	☐☐ Stroke / CVA (N)
☐☐ HIV/AIDS	☐☐ Hepatitis A/ B / C	☐☐ Arthritis (M)	☐☐ Pregnant/Nursing
☐☐ Tuberculosis	☐☐ Heart Disease (CV)	☐☐ Sickle Cell	☐☐ STD's

List all major surgeries/injuries/hospitalizations: ☐ NONE _____

OCULAR HISTORY: current/chronic history or surgery for any of the following**: Last eye exam date**: _____

Y N	Y N	Y N	Y N
☐☐ Cataract	☐☐ Injury/Eye Patching	☐☐ Blurred Vision	☐☐ Eye Pain
☐☐ Macular Degeneration	☐☐ Double Vision	☐☐ Eye Strain	☐☐ Redness
☐☐ Glaucoma/Suspect	☐☐ Loss of side Vision	☐☐ Floaters	☐☐ Sting/ burn/ itch/tenderness
☐☐ Retinal Tear/Hole/Detach	☐☐ Lasik/RK	☐☐ Flashes of light	☐☐ Foreign Body Sensation
☐☐ Droopy Eyelid	☐☐ Bifocal	☐☐ Light Sensitivity	☐☐ Mucous Discharge
☐☐ Strabismus (crossed eye)	☐☐ Contacts	☐☐ Dark Shadow/Curtain/Veil	☐☐ Sandy/Gritty Sensation
☐☐ Amblyopia (lazy eye)	☐☐ Prism	☐☐ Dryness	☐☐ Excessive Watering

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Are you currently under the care of another eye specialist? ☐No ☐ Yes If yes, Dr._____

Condition: _____Last Appt. Date_____ Next Appt. Date_____