Huet Eye Associates, P.C.

Patient Information:

Name:_____ Home Phone_____

Address:_____ Cell Phone_____

City:_____State_____Zip_____ Email_____

D.O.B._____SS#_____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer _____ Occupation _____

Insurance Information:

Primary Insured Name _____ Primary Insured SSN:_____

Relationship _____ Primary Insured D.O.B. _____

Primary Care Doctor _____ Phone # _____

Patient History:

Reason for today's exam _____

Location of last exam _____Date of last Exam _____Referred by:_____

Do you currently wear Glasses or CL's? _____ Satisfied with present Rx (Y/N)?_____

Hobbies _____ Sports _____ Computer use (Y/N) _____ Hrs/Day_____

At today's visit what would you like to be examined for: ____ Eyeglasses ____ Contacts ___Both

Please list all medications you are taking _____

_____ Drug allergies: _____

History of eye injury (date/which eye) _____

History of eye surgery (date/which eye/surgeon) _____

Family Eye History (Please check)___Cataracts ___ Glaucoma ___ Macular Degeneration ___Other_____

Cigarette use (Y/N) ____ Recreational drugs (Y/N) ____ Alcohol use (Y/N) ____

Medical History: Please check Neg. if not applicable

Allergic/Immunologic Neg.____
- ☐ Drug Allergy
- ☐ Environmental Allergy
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Other
- ☐ Meds

Ears, Nose, Mouth & Throat Neg.____
- ☐ Upper Resp. Trae Infect.
- ☐ Other
- ☐ Meds

Gastrointestinal Neg.____
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Digestive
- ☐ Other
- ☐ Meds

Integumentary Neg.____
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Other
- ☐ Meds

Psychiatric Neg.____
- ☐ Depression
- ☐ Panic Disorder
- ☐ Schizophrenia
- ☐ Other
- ☐ Meds

Cardiovascular Neg.____
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Vascular Disease
- ☐ Other
- ☐ Meds
- ☐ Cholesterol

Endocrine Neg.____
- ☐ Non-Insulin Dependent Diabe
- ☐ Insulin-Dependent Diabetes
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction
- ☐ Other
- ☐ Meds

Genitourinary Neg.____
- ☐ STD viral herpetic, Chlamydia
- ☐ Other
- ☐ Meds

Musculoskeleral Neg.____
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Ankylosing Spondylitis
- ☐ Other
- ☐ Meds

Respiratory Neg.____
- ☐ Cigarette Smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Other
- ☐ Meds

Constitutional Neg.____
- ☐ Developmental Disability
- ☐ Weight Loss
- ☐ Fever
- ☐ Fatique
- ☐ Trauma
- ☐ Other
- ☐ Meds

Eyes Neg.____
- ☐ GLC
- ☐ CAT
- ☐ AMD
- ☐ Surgery
- ☐ Inflammatory Disorders
- ☐ Other
- ☐ Meds

Hematologic/Lymphatic Neg.____
- ☐ Anemia
- ☐ Large Volume Blood Loss
- ☐ Leukemia
- ☐ Other
- ☐ Meds

Neurological Neg.____
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Other
- ☐ Meds

☐ Primary ROS taken today ☐ Reviewed ___/___/___ ROS today Initials: _____

Huet Eye Assoc., P.C.

Michael Huet, O.D., Janice Huet, O.D., Elmer Ebeck, O.D.

HIPAA PRIVACY
AND ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

I, _____ [Please print full legal name here] (the "Patient" of "Patient's legal representative") have been presented with the notice of Privacy Policy (the "Policy") of Huet Eye Assoc., P.C. (the Provider"), and have been offered a copy of such policy to keep for my records.

_____ [Please initial here] I hereby acknowledge that I have been provided with a copy of the policy.

_____[Please initial here] I hereby refuse to acknowledge receipt of the Policy. I understand that even though I may refuse to sign this acknowledgement, Provider may still provide treatment to me.

_____

Signature of Patient Date

For Office Use Only

I,_____[Please print full name here], acting as _____[Please print relationship to or official position with provider] for Provider attempted to obtain the written acknowledgement of receipt of the Policy of Provider on _____[Insert date that attempt was made], but acknowledgement could not be obtained because:

_____[Please initial here] Patient or patient's legal representative refused to sign.

_____[Please initial here] Patient of patient's legal representative could not be communicate with sufficient to obtain knowledge.

_____[Please initial here] Emergency circumstances prevented securing acknowledgement.

_____[Please initial here] Other (Please Specify) _____

_____

Signature of Provider Representative Date