Patient History Questionnaire

IMPORTANT: To be reviewed at each appointment. All information is strictly confidential.

		Finct name:		Middle:	
_ast Name: Address:		City:		State:	Zip:
Address: Home phone:	343	Work phone:	i seem I bear	Cell:	N 12505 - 17554 St 1
	Syd Assmal tantant	Work phone.	Maria San Carana da Cara	Fax #:	HW WITHOUT US
E-mail address: Communication Prefere	Dhana	Call Phone	Work Phone	F-mail Fax	sy, i stant i ye
Communication Pretere Patient SS#:/	nce: Home Phone	VF If a stu	dent what sch	ool and arade:	
Date of Birth:	Acc W	onk place:		Occupation:	a feet may have a
Date of Birth:	Age vv	ork piace.		Phone number:	MARKET PRESENCE LINE
Emergency contact per Marital Status: M 5	son:	D-6	hham?	I HORE HURBER	
Marital Status: M S	b Sep. Wia.	Keterred 10	us by whom?		
Family Members: Spou	S.P.	Childr	en		
Ren/	Sis (if pt. is a minor)	PREST AS A	and the second		
	nts				
Ethnicity: Hispanic	Metive Hemeijan	Not Hispanic	or Latino Pre	ferred Language:	so I southwise yo
Ethnicity: Hispanic	INGIINE LIGMONIAN	1401 Trispanie	or barmo inc	terroa bangaago	arr ver herseurseg
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	stad Tn	curance In	formation	Perent/Sucrition Si	
Prim. Insured name: _					
Prim. Insured name: _		_ Employer		c#	DOR
Sec. Insured name:		_ Embloyer	sering to s		N
Primary Care Physician	Casa front ass your live	A LOS COMES OF STREET	Exam results	sent to them?	or iv
	N you choose to sign on	edical Inf	ormation		
How is your general he		isfleq has spands	of invitages en age	THE THICK THAT MELD BING BOY	contacts and you
Do you take any medic	ations for any of the	following syst	tems? (circle Y	or N)	
•	//N Nervous		crine Y/N		
0 20 11 1 11 11 11	//N Blood/Lympl	y/N Card	iovascular Y/N	Muscle/Bones	y/N
Respiratory	Y/N Integ/Skin		Company of the second s	Mental/Psychiat	
High blood pressure		Y/N Diab	etes Y/N v	which type?	biotdo bas tapqua
Nerve problems	//N Arthritis	Y/N			
Please list your medica	tions:	THE TAX BUTT OF TO	tika ofti Atlane es	pipala to say of parago	A Transport
	mer aw tast minisak s ass				
	regad 3.U ait of phololo	the safetime bear		er natakan anta an an	I passesses are not
Allergies to Medication	ıs:	3257		NOTIFIC TO A STATE OF THE STATE	Head deat not '550-400
-					The state of the s
	Parisi san ironia anna a				
Have you smoked in th	e past? Y/N Do y	ou currently sn	noke? Y/N Ho	w much?	ditoniopen ene alli
Do you drink alcohol?	And the second of the second o	sionally/Sociall		and to become the set too	Tractions and full
		, when is your			Sensia pinecesso
Are you currently preg	nant? 7/14 (11 50	, when is your	due duie:		and the last to the
	n description of indorest	M-di-1/0	aulas Hist.	iduli set kaseices nepe	
			cular Histo	Museum at trigits out to	
		parents or sib		aracts Lazy/Cro	seed Eve
High Blood Pressure	Diabetes	Retinal detacl			ossed Eye
Macular degeneration	Glaucoma	High Astigma	rism Arti	hritis Poor Eye	signi
Other ave diseases					MATERIAL TO STANDARD STANDARD

Personal Eye Information

When was your last eye examination? _	Did	you get glasses, contacts, or	neither?
What is the primary reason for today's	visit?	3	SmentA was
What is your main complaint today?	1441		128591
Do you currently wear: Eyeglasses Co	ntact Lenses (type and sch	edule	Total
Today, I want to get: Eyeglasses Sur	nglasses Computer Glasses	Contact Lenses Eye Medical	reatment
Vision Exam onl	y Driver's License Exam	Special Testing	noirpalauman
Have you had any eye surgery or recen	t eye injury? Y/N (date	M · weil	
Do you have: Cataracts /Macular Dege	neration / Dry Eyes / Ret	inal Detachment / Glaucoma /	Loss of Vision
Describe your eye or vision symptoms:		This case of the state of the s	KES VSESSIAN
	Smarke ud as se house.	Will use g a M	with 2 last and
	Children	es: Spouse : 20	
	Consent to Trea	Bro/Sis (if pt. is a minor)	
By my signature, I consent to treatment fo	r myself or on behalf of this	patient as their legal parent or g	uaraian. I give
my permission for the doctor and staff to	examine, diagnose, and treat	as deemed necessary or appropria	ile. T lai inci
sign that I am responsible for the payment	of both services and materia	is that my insurance does not cove	El did
understand that legal action will be taken if	I do not tinancially satisfy	ny obligations.	
Patient/Parent/Guardian Sign	nature	Date	
A Chemist at emissage and one	grence Informerson		
Notice	of Privacy Practice	Summary	
This notice is a summary of how your protected	health information is used. For a	full copy, see front desk assistant.	
the late information about your for theatma	ent to obtain navment for admir	distrative use, and to evaluate the government	ility of care you
· tate identifiable health informed	kon about vou without vour durno	rization for public neutrin parposes,	
to the discountry of the property of the prope	ride information when otherwise r	Sudil-sa by ide agert as to tar	
To any other situation we will ask for your writt	en authorization before using it.	If you choose to sign an administration	, ,
revoke it to stop any future disclosures. We ma	ry be required to change our polic	ies by law and these will be posted in	the reception
room along with the full disclosure.			
Your rights:	V/V Endocrine Y/N	L. 4E CED 164 522	
request a restriction on certain uses and dis	closures of your into as provided	by 45 CFR 164.522	
. obtain a paper copy of the notice of privacy	practices upon request		
inspect and obtain a copy of your health rec amend your health record as provided in 45	CFR 164 528	energing V/N Headaches	
obtain an accounting of disclosures of your h	realth info as provided in 45 CFR	164.528	
request communications of your helath info b	by alternative means or at alterna	ative locations	
. revoke your authorization to use or disclose	health info except to the extent	that action has already been taken	
If you are concerned that we have violated your	national sinks on you discome u	with a decision that we made about ac	cess to your
It you are concerned that we have violated your records, you may contact the person listed below	You also may send written com	applaints to the U.S. Department of H	ealth and Human
Services. The person listed below can provide y	ou with this address.	The print of the section of the sect	
oct vices.		- 61 (6) (1) (1) (1)	
Our Legal Duty:			
We are required by law to protect the priva	cy of your information, provide t	his notice about our information	
Practices, and follow the information practic	ies that are described in this not	unfreeshorn Tn 37129. Phone (615)	Hove you saw
complaints, please contact Jeffrey C. McCla	in, Ob, 1132 W. Clark Blvd., Mil	in the east of the contract of	
893-0149 or email jeffmcclain59@gmail.com	i. With son may a nanw		
I acknowledge that I have reviewed the Notice	of Privacy Practice which provide:	s a description of information uses and	disclosures. I
understand that I have the right to request res	trictions as to how my health info	ormation may be used or disclosed and	that the
organization is not required to agree to the rest	rictions I request.		
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Cincolne of Potions on Level Counting	Date	Witness	Date
Signature of Patient or Legal Guardian	54.0	292000	