

# WELCOME TO NUCCIO OPTOMETRISTS

Date: \_\_\_\_\_

Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( \_\_\_\_ ) \_\_\_\_\_

Work Phone: ( \_\_\_\_ ) \_\_\_\_\_ Ext: \_\_\_\_\_ Name: \_\_\_\_\_

Email: \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Distance driven: \_\_\_\_\_

Spouse/Parent: \_\_\_\_\_

Work Phone: ( \_\_\_\_ ) \_\_\_\_\_ Ext: \_\_\_\_\_

Number of years since last exam: 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_ 4 \_\_\_\_ 5+ \_\_\_\_

By whom: \_\_\_\_\_

## Reason for your visit:

- |  |  |
|--|--|
| <input type="checkbox"/> contact lenses                | <input type="checkbox"/> broken/lost contact lens          |
| <input type="checkbox"/> new glasses                   | <input type="checkbox"/> broken/lost glasses               |
| <input type="checkbox"/> eye redness/pain              | <input type="checkbox"/> blur/strain looking at a distance |
| <input type="checkbox"/> annual exam                   | <input type="checkbox"/> blur/strain looking near          |
| <input type="checkbox"/> headache                      | <input type="checkbox"/> blur/strain looking at computer   |
| <input type="checkbox"/> other - please explain: _____ |  |

Do you presently wear contact lenses? yes \_\_\_\_\_ no \_\_\_\_\_

Number of eyeglasses you presently own: \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_

Insurance: yes \_\_\_\_\_ no \_\_\_\_\_ name: \_\_\_\_\_

Member ID: \_\_\_\_\_

## ACTIVITIES

(Please check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> golf                  | <input type="checkbox"/> computers                |
| <input type="checkbox"/> jogging/running       | <input type="checkbox"/> woodworking/metal crafts |
| <input type="checkbox"/> basketball/baseball   | <input type="checkbox"/> automotive/driving       |
| <input type="checkbox"/> tennis/racquet sports | <input type="checkbox"/> gardening/lawn care      |
| <input type="checkbox"/> cycling               | <input type="checkbox"/> music/reading            |
| <input type="checkbox"/> skiing                | <input type="checkbox"/> knitting/needlework      |
| <input type="checkbox"/> swimming/scuba diving | <input type="checkbox"/> painting                 |
| <input type="checkbox"/> hunting/shooting      | <input type="checkbox"/> stamp/coin collecting    |
| <input type="checkbox"/> boating/fishing       | <input type="checkbox"/> photography              |
| <input type="checkbox"/> hockey                | other _____                                       |

## EYE HEALTH

Do you have a history of:

- cataracts
- glaucoma
- eye injury
- eye surgery
- lazy eye
- eye patching
- double vision
- macular degeneration

Does your family have a history of:

- cataracts
- glaucoma
- eye disease
- lazy eye
- diabetes
- high blood pressure

## GENERAL HEALTH

Number of years since last medical exam: \_\_\_\_\_

Do you have a history of:

- diabetes
- high blood pressure
- high cholesterol
- stroke
- heart attack
- head injury
- allergy
- arthritis
- sinus
- tumor
- cancer
- HIV

If over 13:

- alcohol use
- tobacco use
- illegal drug use

Any known allergy to medications?

List all medications you currently take:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

please continue on back if needed.

**Patient Consent to the Use and Disclosure of Health Information  
for Treatment, Payment, or Healthcare Operations**

I, \_\_\_\_\_, understand that as part of my health care, Nuccio Optometrists originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health care information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Nuccio Optometrists is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Nuccio Optometrists reserves the right to change their notice and practices and prior to implementation, in accordance with section 164.520 of the Code of Federal Regulations. Should Nuccio Optometrists change their notice, they will send a copy of any revised notice to the address I have provided (whether U.S. mail or, if I agree, e-mail).

I wish to have the following restrictions to the use or disclosure of my health information:

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I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept/decline the terms of this consent.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

**FOR OFFICE USE ONLY**

[ ] Consent received by \_\_\_\_\_ on \_\_\_\_\_.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on \_\_\_\_\_.