Welcome to our Office

DR. CHARLENE HAYNES
DR. ANNA MCKINNEY
THERAPEUTIC OPTOMETRISTS

Patient's Name: _____ Other: _____

○ Mr. ○ Mrs. ○ Ms. ○ Miss ○ Dr. (name you would like to be called)

Address: _____

Street City State Zip

Date of Birth: ____/____/____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

You prefer to be contacted via: ○ Email ○ Cell ○ Work ○ Home

Employer/School: _____ Spouse's Name: _____

Patient's Social Security Number: _____ Responsible Party: _____

How did you find our office? ○ Location ○ Provider List Friend (name) _____

Current medications: _____

Are you allergic to any medications? Y/N If yes - please list _____

Are you pregnant? Y/N Are you currently breastfeeding? Y/N Do you wear contacts? Y/N

Is there a history of any of the following with you or your family? If yes, please indicate specific person below.

Glaucoma _____ Diabetes _____ High Blood Pressure _____

Cataracts _____ Macular Degeneration _____ Retinal Detachment _____

Other eye conditions? _____

Do you experience headaches on a regular basis? Y/N

Do you use cigarettes/tobacco? Y/N Alcohol? Y/N Other substance?

Other health problems/concerns? _____

Have you had any surgeries? Y/N Type/Date: _____

Have you had any eye operations? Y/N Type/Date: _____

Have you had any eye injuries? Y/N Type/Date: _____

Are you interested in contacts? Y/N Are you interested in Lasik? Y/N

Please remember that insurance in considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any prefessional services rendered. FULL PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.

I HEREBY AUTHORIZE RELEASE OF MEDICAL RECORDS TO MY INSURANCE COMPANY.

Signature _____ Date _____

Our Notice of Privacy Practices
By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change our Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new Notice in our offive, as well as have copies available in our office.

Complaints
If you think that we have not properly respected the privacy of your health information, you are free to file a complaint with our office or the U.S. Department of Health and Human Services Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to file a complaint with our office, send a written complaint to the office contact person at the address, fax or e-mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

I acknowledge that I have reviewed a copy of Dr. Charlene Haynes' Notice of Privacy Practices.

Signature _____ Date _____

Patient Name _____