Scott Hussey O.D. LLC

"Eye Care at its Best"

532 Old Smizer Mill Road • Fenton, MO 63026
Phone: (636) 305-7110 • Fax: (636) 305-9509 • www.scotthusseyod.com

Last Name _____ First Name _____ MI ____ Today's Date _____
Address _____ City _____ State _____ Zipcode _____
Cell Phone _____ Home Phone _____ SSN _____
Work Phone _____ Ocupation _____
Date of Birth _____ Email _____ Employer _____
Whom may we thank for your referral to our office? _____

Race and Ethnicity:
☐ Unknown ☐ African American ☐ American Indian ☐ Arab ☐ Asian
☐ Caucasian ☐ Hawaiian ☐ Hispanic Latino ☐ Indian ☐ Multiracial

Preferred Language: _____
☐ Hispanic or Latino ☐ Not Hispanic or Latino
Gender: ☐ Male or ☐ Female
Dominant Hand: ☐ R or ☐ L

Medical Information

What is your general health? _____ Height _____ Weight _____
Do you have problems with any of these systems? **(Please circle yes or no)**

Ears/Nose/Throat	☐ YES ☐ NO	High Blood Pressure	☐ YES ☐ NO	Integumentary (skin)	☐ YES ☐ NO
Neurological	☐ YES ☐ NO	Respiratory	☐ YES ☐ NO	Endocrine/Diabetes	☐ YES ☐ NO
Headaches	☐ YES ☐ NO	Gastrointestinal	☐ YES ☐ NO	Blood/Lymph	☐ YES ☐ NO
Psychiatric	☐ YES ☐ NO	Urinary	☐ YES ☐ NO	Allergic/Immunologic	☐ YES ☐ NO
Cardiovascular	☐ YES ☐ NO	Muscles/Bones	☐ YES ☐ NO	Pregnant	☐ YES ☐ NO
				Nursing	☐ YES ☐ NO

Please explain _____
Diabetes ☐ YES ☐ NO Type _____ Date of diagnosis _____
Allergies to medication? ☐ YES ☐ NO Which? _____ Reactions _____
Other health problems _____
Current medication(s) _____ Check if none ☐
Have you had any operations? ☐ YES ☐ NO Type _____ When _____
Name of family doctor _____ Doctors phone number _____
Date of last visit _____ Date of last tetanus shot _____
Last eyecare provider _____ Date of last eye examination _____
Perferred Pharmacy _____ Location _____ Phone _____

Smoking History
☐ Current Every Day Smoker
☐ Current Occasional Smoker
☐ Former Smoker
☐ Non Smoker

Do you drink alcohol? ☐ YES ☐ NO _____
Do you use illegal drugs? ☐ YES ☐ NO _____
Have you ever been exposed to or infected with: ☐ HIV ☐ Hepatitis

Family History

High blood pressure	☐ YES ☐ NO Relation _____	Macular degeneration	☐YES ☐ NO Relation _____		
Diabetes Type 1/2	☐ YES ☐ NO Relation _____	Retinal detachment	☐YES ☐ NO Relation _____		
Cancer	☐ YES ☐ NO Relation _____	Cataracts	☐ YES ☐NO Relation _____		
Hyper/Hypo Thyroid	☐ YES ☐ NO Relation _____	Glaucoma	☐ YES ☐ NO Relation _____		

Personal Eye Information

Do you have any eye conditions or problems? ☐ YES ☐ NO What kind? _____
Have you had any eye operations? ☐ YES ☐ NO Type _____ Date _____
Have you had an eye injury? ☐ YES ☐ NO Type _____ Date _____

Do you have glaucoma?	☐ YES ☐ NO	Cataracts?	☐ YES ☐ NO	Dry/Red/Gritty eyes?	☐ YES ☐ NO
Macular degeneration?	☐ YES ☐ NO	Retinal detachment?	☐ YES ☐ NO	Blurred vision?	☐ YES ☐ NO
Do you wear glasses?	☐ YES ☐ NO	Contact lenses?	☐ YES ☐ NO	Type _____	

Interested in Lasik? _____

Vision Source

Insight Source

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Scott Hussey, OD, LLC make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ I have read or had explained to me Scott Hussey, OD, LLC's Notice of Privacy Practice and agree to continue my care with Scott Hussey, OD, LLC under said terms.
- ☐ I was given to opportunity to read Scott Hussey, OD, LLC's Notice of Privacy Practices and declined but wish to continue my care with Scott Hussey, OD, LLC under the terms of Scott Hussey, OD, LLC's privacy policies.
- ☐ I have read or had explained to me Scott Hussey, OD, LLC's Notice of Privacy Practice and do not wish to continue my care with Scott Hussey, OD, LLC under said terms.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

_____
_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____
Representative Relationship to Patient

Patient Financial Responsibility

I authorize Scott Hussey OD, LLC, Dr. Scott Hussey, to apply for benefits on my behalf for any services performed by him and staff. I agree and assign my benefits and request that all payments from my insurance plan(s) be made directly to the above provider, Dr. Scott Hussey. I agree to and assume responsibility of any unpaid balances not covered by my insurance plan(s), or to assume full responsibility for patient fees if I have no insurance coverage.

Patient Signature: _____ Date: _____
If the patient is a minor, parent or guardian is required to sign above.

Responsible Party Signature (if different than above):
_____

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name _____

Patient Address _____

Patient Phone Number _____

I authorize Scott Hussey, OD, LLC to release health information identifying me (including, if applicable, information about substance abuse, mental health conditions, and HIV infection or AIDS) under the following conditions:

This form is an agreement to the release of all medical information pertaining to the above listed patient from all providers at the below listed location(s):

_____

_____

_____

Scott Hussey OD, LCC stands no monetary gain at the acquisition or release of patient records. This form will expire five years from the date of signature. It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you may revoke it at any time by contacting in writing, FAX or email the Privacy Official noted in the *Notice of Privacy Practices.*

When your health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Date

If you are signing a personal representative of the patient, please indicate your relationship

_____ _____

Representative Relationship to Patient

VISION SOURCE