

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 _____ Occupation _____
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	<input type="checkbox"/> YES <input type="checkbox"/> NO	High Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Integumentary (skin)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Neurological	<input type="checkbox"/> YES <input type="checkbox"/> NO	Respiratory	<input type="checkbox"/> YES <input type="checkbox"/> NO	Endocrine/Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO
Headaches	<input type="checkbox"/> YES <input type="checkbox"/> NO	Gastrointestinal	<input type="checkbox"/> YES <input type="checkbox"/> NO	Blood/Lymph	<input type="checkbox"/> YES <input type="checkbox"/> NO
Psychiatric	<input type="checkbox"/> YES <input type="checkbox"/> NO	Urinary	<input type="checkbox"/> YES <input type="checkbox"/> NO	Allergic/Immunologic	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cardiovascular	<input type="checkbox"/> YES <input type="checkbox"/> NO	Muscles/Bones	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pregnant	<input type="checkbox"/> YES <input type="checkbox"/> NO
Please explain _____				Nursing	<input type="checkbox"/> YES <input type="checkbox"/> NO

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 _____

Preferred Pharmacy _____ Location _____ Phone _____

Smoking History Do you drink alcohol? YES NO _____

Current Every Day Smoker Do you use illegal drugs? YES NO _____

Current Occasional Smoker

Former Smoker Have you ever been exposed to or infected with: HIV Hepatitis

Non Smoker

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

Scott Hussey

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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