LESNICK OPTICAL
13350 Fort St.
Southgate, MI 48195
Phone 734-284-2020
Fax 734-284-0020

Today's Date:

PATIENT HISTORY QUESTIONNAIRE

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name: First Name: MI:

Address: City: State: Zip:

Daytime Phone: ( ) Home Phone: ( )

D.O.B.: Occupation: Employer:

Emergency Contact Name: Phone Number: ( )

Date of Last Eye Exam: Dilated: YES/NO

E-Mail:

MEDICAL INFORMATION

What is your general Health?

Do you have problems with any of these systems? (Please circle yes or no)

Gastrointestinal	Yes/No	Nervous?	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary	Yes/No	Headaches	Yes/No
High Blood Pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain:

Do you have Diabetes Yes/No Type: Date Of Diagnosis:

Allergies to medication? Yes/No Which? Reactions:

CURRENT MEDICATION(S)

Have you had any operations? Yes/No Kind? When?

Name of family doctor: Address: Phone:

Name of Pharmacy: Location: Phone:

Family History

High Blood Pressure Yes/No Relation Macular Degeneration Yes/No Relation

Diabetes Yes/No Relation Retinal Detachment Yes/No Relation

Glaucoma Yes/No Relation Cataracts 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 What kind?

Have you had an eye injury? Yes/No What kind?

Do you have glaucoma? Yes/No Cataracts? Yes/No Dry Eye? 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:

Additional Information:

- See back for insurance information

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INSURANCE INFORMATION

Insurance Carrier: ID Number:

Subscriber Name: Relationship:

Subscriber Date Of Birth: Employer:

SECONDARY INSURANCE

Insurance Carrier: ID Number:

Subscriber Name: Relationship:

Subscriber Date Of Birth: Employer:

MEDICAL INSURANCE

Insurance Carrier: ID Number:

Subscriber Name: Relationship:

Subscriber Date Of Birth: Employer:

I hereby authorize any necessary medical treatment by the optometrists in the practice of Lesnick Optical agree to be responsible for my bill and any collection fees made necessary to collect payment of services rendered. I authorize this office to release any information necessary to expedite insurance claims. I further authorize the office Lesnick Optical to release or obtain any required medical information from my attending physicians or any medical facility. **ACKNOWLEDGEMENT:** I HAVE READ OR REQUESTED A COPY OF THE PRIVACY PRACTICES.

Patient's Signature Date:

Lesnick Optical

"Quality Eye Care"

13350 Fort Street • Southgate, MI 48195
Phone 734-284-2020 - Fax 734-284-0020

Dr. Aaron L. Scheinker
www.lesnickoptical.com
lesnickoptical@gmail.com

NOTICE OF PRIVACY PRACTICES

Effective date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures of Health Information

With your consent, we may use health information about you for treatment (such as sending your medical record information to a specialist physician as part of a referral), to obtain payment for treatment (such as sending billing information to a health insurance plan), for administrative purposes, and to evaluate the quality of care that you receive (such as comparing patient data to improve treatment methods).

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for workers' compensation purpose, and emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. We may also contact you about appointment reminders or treatment alternatives. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual Rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you.

You have the right to request that your health information be communicated to you in a confidential manner such as sending mail to an address other than your home. If this notice was sent to you electronically, you may obtain a paper copy of the notice.

You may request in writing that we not use or disclose your information for treatment, payment, or administrative purposes or to persons involved in your care except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

Aaron Scheinker O.D.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Lesnick Optical Notice of Privacy Practices

Patient Name____

Signature________________________________ Date__________