34 Plaza Street East
Suite: 103
Brooklyn, NY 11238
Phone: (718)638-2020
Fax: (718)230-3429

Edward F. Smith, M.D. **Peter D. Berg, M.D.**

PATIENT NAME: ____DATE OF BIRTH: ______________________

ADDRESS: ____SEX: _______AGE: ______

CITY: ____STATE: ________________ZIP CODE: _________________

HOME PHONE: __________________________________WORK PHONE: ___________________________________

CELL PHONE: ________________________S.S #:______________________ EMAIL: _________________________

PRIMARY CARE PHYSICIAN: ___________________________ REFERRED BY: ________________________________

PHARMACY NAME: ____PHONE NUMBER: ______________________

BILLING NAME AND ADDRESS (IF DIFFERENT FROM ABOVE):____

____

____

EMPLOYMENT INFORMATION

EMPLOYER: ____

ADDRESS: ____CITY:____

STATE: ______________ZIP CODE: ____________________PHONE NUMBER: _______________________________

INSURANCE INFORMATION

NAME OF INSURED: ____

INSURANCE COMPANY: ____

ADDRESS OF INSURANCE COMPANY: ____

____

POLICY #: ____

SECONDARY INSURANCE (IF ANY):____

ADDRESS OF SECONDARY INSURANCE: ____

____

SUBSCRIBER: ____

POLICY#:____D.O.B___________________________________

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MEDICAL HISTORY FORM

Name____ Today's Date ____/____/____
Birth Date ____/____/____ Social Security #____-_____-____ Phone#____________________
Preferred Language __________________ Race_________________ Last Eye Exam ____/____/___
Name of Medical Doctor _____________________________________ Height______ Weight_______
Last Medical Exam ____/____/____Primary Care Physician Phone #_______________________________

Medical History

Do you have any allergies to medications? ☐ Yes ☐ No If yes, explain _____________________________
____
List any medications you take (including oral contraceptives, aspirin, over the counter medications ect...)
____
____
____
List all major injuries, surgeries, and/or hospitalizations you have had ____________________________
____
____
List all previous eye disease, trauma or eye surgeries ____
____
____
Are you pregnant or nursing? ☐ Yes ☐ No
Do you wear glasses? ☐ Yes ☐ No If yes, how old is your present pair of eyeglass lenses? ___________
Do you wear contact lenses? ☐ Yes ☐ No If yes, how old is your present pair of contacts? ___________
Type of contact Lenses ☐ Rigid ☐ Soft ☐ Extended wear ☐ other. Are they Comfortable? ☐ Yes ☐ No

FAMILY HISTORY

Please note any family history (Parents, Grandparents, Siblings, Children; living or deceased).

Blindness	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Cataract	☐ Yes ☐ No	Macular Degeneration	☐ Yes ☐ No
Crossed Eyes	☐ Yes ☐ No	Retinal Detachment/ Disease	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No

Other __________________________________

**************** **PLEASE TURN TO SECOND PAGE*****************

Downstate Ophthalmology Associates

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SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the Doctor if you prefer. ☐ Yes, I would like to discuss my social history directly with the doctor.

Do you drive? ☐ Yes ☐ No if yes, do you have visual difficulty when driving ☐ Yes ☐ No

If yes, please describe ____

____

Do you use tobacco products? ☐ Yes ☐ No If yes, Type/amount/how long__________________________

Do you drink alcohol? ☐ Yes ☐ No If yes, Type/amount/how long__________________________

Do you use illegal drugs? ☐ Yes ☐ No If yes, Type/amount/how long__________________________

Have you ever been exposed to or infected with ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

REVIEW OF SYSTEMS

Do you currently or have you ever had any problems in the following area?

CONSTITUTIONAL	**YES**	**NO**
Fever, Weight Loss/ Gain	☐	☐
Integumentary (SKIN)	☐	☐
NEUROLOGICAL	**YES**	**NO**
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
EYES	**YES**	**NO**
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision/Halos	☐	☐
Double Vision	☐	☐
Loss of Side Vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy or Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Chronic Infection of Eye/Lid	☐	☐
Styes or Chalazion	☐	☐
Flashes/Floaters in vision	☐	☐
Tired Eyes	☐	☐
ENDOCRINE	**YES**	**NO**
Thyroid/Other Glands	☐	☐

DIABETES	☐	☐
EARS, NOSE, MOUTH, THROAT	**YES**	**NO**
Allergies/Hay fever	☐	☐
Sinus Congestion	☐	☐
Runny Nose	☐	☐
Post-Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Throat/Mouth	☐	☐
RESPIRATORY	**YES**	**NO**
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
VASCULAR/CARDIOVASCULAR	**YES**	**NO**
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
GASTROINTESTINAL	**YES**	**NO**
Diarrhea	☐	☐
Constipation	☐	☐
GENITOURINARY	**YES**	**NO**
Genitals/Kidney/Bladder	☐	☐
BONES/JOINTS/MUSCLES	**YES**	**NO**
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
LYMPHATIC/HEMATOLOGIC	**YES**	**NO**
ANEMIA	☐	☐
ALLERGIC/IMMUNOLOGIC	☐	☐
PSYCHIATRIC	☐	☐

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NOTICE OF PRIVACY

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

The Health Information Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This act gives the patient significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information. We may disclose your medical records only for each of the following purposes; treatment, payment and healthcare operations. Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination. Payment means such activities as obtaining reimbursement for services rendered, confirming coverage, billing or collection and utilization review. An example of this would be sending a bill for your visit to your insurance company for assessment, Improvement activities, Auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other use and disclosure will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

I have received, read, and understand your notice of privacy practices for the use and disclosure of medical information. I understand that this office has the right to change its notice of privacy practices from time to time and that I may contact this office at any time to receive a current copy

Patient Name: ____ Date: ____________________________

Signature: ____ Guardian: ____

OFFICE USE ONLY

I attempted to obtain patient’s signature in acknowledgement of this notice of privacy practices but was unable to do so as documented below:

Date: _________________________ Name: ____Initials:_____________

Reason: ____